
Southeast Radiology Management e-News

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Many of our subscribers have inquired about resources for learning interventional radiology coding. In response to these inquiries, we will offer a series of short articles on interventional radiology procedures, starting with the basics and working our way through instruction on various interventional procedures. We hope that this series will meet the needs for those of you just starting out on your IR journey or for those who simply need a refresher. Enjoy!

Interventional Radiology Coding: Key Terms

To fully grasp the nuances of interventional radiology coding, one must have a clear understanding of the terminology utilized in coding for these procedures. This article will discuss those key terms that are the foundation for all interventional procedures.

Access

The first piece of the puzzle in determining the catheterization codes that should be assigned for a particular case is the point of access. It will be a key factor in whether a non-selective or selective catheter placement code is assigned, as well as determining vessel order.

Access for most interventional radiology procedures is gained via the axillary/brachial artery or vein in the upper extremity or via the common femoral artery or vein in the lower extremity, with the majority of procedures performed via the common femoral.

Vascular Family

A vascular family is a group of arteries (or veins) which arise from a primary branch of the aorta (or vena cava), or the vessel that is punctured.

The number of vascular families and the specific vascular families catheterized will also determine how many catheterization codes are assigned for a particular procedure. If multiple vascular families are catheterized, each vascular family is coded separately.

Vascular Order

Vascular order refers to the branching pattern of a vascular family. First order branches arise from the aorta (or vena cava), or the vessel that is punctured. Second order branches arise from first order branches and third order branches arise from second order branches.

Non-Selective Catheterization

Nonselective catheter placement means the catheter is placed directly into an artery (or vein) and is not advanced further into a branch or is advanced only into the aorta (or vena cava) from any approach.

Selective Catheterization

Selective catheter placement means that the catheter is advanced beyond the vessel punctured or beyond the aorta or vena cava into a vascular family. Selective catheterization involves first, second, and third order or higher degree vessels.

Ipsilateral

The term ipsilateral refers to the same side. For interventional procedures the term ipsilateral indicates that the intervention is being performed on the same side of the body as the point of access.

Contralateral

The term contralateral refers to the opposite side. For interventional procedures the term contralateral indicates that the intervention is being performed on the opposite of the body as the point of access.

Antegrade

The term antegrade means moving in the same direction of blood flow.

Retrograde

The term retrograde means moving backward or against the flow of blood.

Let's Put It All Together!

Example 1: *Access is gained at the right common femoral artery. The physician advances the catheter to the aorta, injects contrast and provides an interpretation for an abdominal aortogram.*

This example demonstrates non-selective catheterization (36200). The catheter was advanced to the aorta and was not manipulated any further.

Example 2: *Access is gained at the right common femoral artery. The physician injects contrast at the distal end of the common femoral and provides an interpretation for an extremity angiogram.*

This example demonstrates a non-selective catheterization (36140). The catheter remained in the common femoral after access was gained into the vessel.

Example 3: *Access is gained at the right common femoral artery. The physician advances the catheter to the aorta, injects contrast and provides an interpretation for an abdominal aortogram, then advances the catheter into the left common carotid for injection and imaging.*

This example demonstrates selective catheterization of a first order vessel (36215). The physician advanced the catheter beyond the aorta and placed the catheter into the left common carotid, a first order branch off of the aorta.

Example 4: *Access is gained at the right common femoral artery. The physician advances the catheter in an ipsilateral antegrade fashion to the superficial femoral, injects contrast and provides an interpretation for an extremity angiogram.*

This example demonstrates selective catheterization of a first order vessel (36245). The physician manipulated the catheter beyond the vessel punctured, the common femoral, and placed the catheter into the superficial femoral a first order branch off of the common femoral. "Ipsilateral antegrade" tells the coder that the catheter remained on the same side as the point of access.

Example 5: Access is gained at the right common femoral artery. The physician advances the catheter in a contralateral retrograde fashion to the left external iliac, injects contrast and provides an interpretation for an extremity angiogram.

This example demonstrates selective catheterization of a second order vessel (36246). The physician manipulated the catheter through the aorta and the common iliac into the external iliac on the left side of the body. The external iliac on the opposite side is a second order vessel which branches from the common iliac, a first order vessel off the aorta. "**Contralateral retrograde**" tells the coder that the catheter was advanced through the aorta into the opposite side of the body.

Example 6: Access is gained at the right common femoral artery. The physician advances the catheter to the left common carotid for injection and imaging. Next he advances the catheter into the left subclavian for injection and imaging and finally to the right common carotid for injection and imaging.

This example demonstrates selective catheterization of multiple vascular families, therefore there will be three catheterization codes assigned for this case: 36215, 36215-59, 36216. (Don't worry, we will discuss modifier use in future issues!)

Catheterization of the left common carotid, a primary (first order) branch off the aorta is 36215, catheterization of the left subclavian, a separate primary (first order) branch off the aorta is 36215, and catheterization of the right common carotid, a second order branch off the aorta is 36216.

In our next issue we will discuss the coding rules for the catheterization codes in more detail.

Question & Answer

Can code 75898 be assigned multiple times for completion angiograms during the same session or should it be assigned only one time per encounter?

Code 75898 is reported only once per operative field, per session. So how does one determine what constitutes an operative field? Although multiple vessels may need to be embolized during the procedure, the key is whether or not those vessels share a common end point. If all of the vessels terminate at the same location (one organ or one tumor), this is considered one operative field.

Here are some examples:

- Multiple vessels feeding a bladder tumor: 1 operative field
- Multiple vessels in the same extremity: 1 operative field
- Bilateral arteriovenous malformations: 2 operative fields
- Embolization procedure performed for the right and left renals: 2 operative fields

Reference: CPT Assistant December 2007

Do you have a question that you would like to see featured in an upcoming issue? If so, send an email to stacie@southeastrad.com

Southeast Radiology Management is pleased to announce that we are offering a FREE radiology coding discussion forum! To subscribe go to: <http://lists.topica/lists/SERADlist>

Upcoming Webinars

Southeast Radiology Management and Health Revenue Assurance Associates have partnered to bring you two [2-hour webinars](#):

Mastering Medical Necessity & ABNs

August 12, 2008

1:00 - 3:00 PM EST

Diagnostic Radiology Coding & Documentation

August 28, 2008

1:00 - 3:00 PM EST

[Click here for additional information and to register.](#)

Simply click on the title of the program to view the agenda.

Claims Paid Under the Medicare Physician Fee Schedule - News from CMS

To the extent possible, the Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other Fee-For-Service (FFS) providers of services paid under the Medicare physician fee schedule, beginning July 1. In this regard, CMS has instructed its contractors to hold these claims for the first 10 business days of July, for dates of service in July. This should have minimum impact on provider cash flow because, under current law, electronic claims are not paid any sooner than 14 days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before June 30 will be processed and paid under normal procedures.

After 10 business days, contractors will begin releasing claims into processing under the fee schedule which implements current law. This, of course, could result in claims being processed with the negative 10.6 percent update. If a new law is enacted which changes the negative 10.6 percent update, retroactive to July 1, CMS is prepared to automatically reprocess most of those claims which have already been processed. Under the Medicare statute, Medicare pays the lower of submitted charges and the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1-June 30, 2008, fee schedule will be automatically reprocessed if Congress retroactively reinstates the update that was in effect for that time period. Any lesser amount will likely require providers to re-submit a revised claim.

To the extent possible, providers may hold claims in-house until it becomes clearer as to whether new legislation will be enacted or until cash flow becomes problematic. This will reduce the need for providers to reconcile two payments (i.e., the initial claim and the reprocessed claim), and it will simplify provider billings of beneficiary coinsurance and payment calculations for payers which are secondary to Medicare.

In addition, be on the alert for more information about other legislative provisions which may affect Medicare FFS providers.

Are you getting all of the revenue to which you are entitled?

Due to the sweeping changes in reimbursement for radiology services it is imperative that you receive all of the reimbursement to which you are entitled. If you are not 100% confident with your charge capture and coding consider an external audit. If you are interested in receiving a quote for services please contact us through our website: www.seradmgt.com

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