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## Catheterization Coding Rules

*In our last issue we focused on defining key terms for interventional radiology procedures. In this issue we are going to focus on the basic coding rules for catheterizations.*

First, let's review the definitions of non-selective and 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** 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.

**There are four main points to remember when assigning catheterization codes:**

**1. Always code selective over non-selective catheterization.** When both a selective catheterization and non selective catheterization are performed from the same point of access, only the code for the selective catheterization is assigned.

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

The catheterization of the aorta is non-selective and the catheterization of the left common carotid artery is selective. Once the catheter is advanced past the aorta, only the code for selective catheterization is assigned, 36215.

If in the above example, the catheter had remained in the aorta and was not manipulated any further, the non-selective catheterization code 36200 would have been the correct code to assign.

**2. Code each vascular family separately.** If more than one vascular family is catheterized, a catheterization code should be assigned for each family.

*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. Three separate vascular families were catheterized therefore there will be three catheterization codes assigned for this case.

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.

Final catheterization codes: 36215-59, 36215-59, 36216.

The -59 modifier is required on the lesser order codes to indicate that a separate vascular family was catheterized. If the -59 modifier is not appended, 36215 will be "bundled" with 36216.

**3. Code each vascular family to the highest order of selectivity.** It is important that the physician documents the final catheter placement and indicates the most distal placement within a vessel, so that the appropriate first, second or third order catheterization code can be assigned.

*Access is gained at the right common femoral artery. The physician advances the catheter to the brachiocephalic for injection and imaging. Next he advances the catheter into the right common carotid for injection and imaging and finally to the right external carotid for injection and imaging.*

Only one family was catheterized, so only one 1st, 2nd or 3rd order catheterization code can be assigned. The brachiocephalic and right common carotid were catheterized on the path to the final destination, the right external carotid (most distal catheter placement). The correct catheterization code for this case is 36217. The lesser order catheterizations are bundled into the highest (3rd order) catheterization.

If the physician catheterizes an additional branch in the same family, add on code 36218 should be assigned. In the example above if the physician had catheterized the right internal carotid in addition to the right external carotid, code 36218 would be added for the additional selective catheterization of the right internal carotid.

**4. Code each vascular access separately.** On occasion the physician may perform a procedure via two separate puncture sites. For these cases, each point of access will yield its own catheterization code.

*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. The catheter is withdrawn and access is gained at the left 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.*

The catheterization code assigned for the first access is 36200, for non selective catheterization of the aorta. For the second access, code 36245 is assigned for selective catheterization of the superficial femoral, a first order vessel. Modifier -59 will need to be appended to code 36200, so the non-selective catheterization will not be bundled with the selective catheterization.

*In our next issue, we will discuss coding rules for diagnostic angiography.*

## Question & Answer

***Our physicians are creating reformatted images from CT exams. For example, a patient will present for a CT of the abdomen and later that day, the radiologist will utilize reconstructions for an examination of the thoracic spine. Can we code for the reconstructed thoracic images? If so, what is the appropriate code to assign?***

If you are coding and billing for the radiologist it is appropriate to code and bill the CPT code for a CT of thoracic spine with the -26 modifier. In the hospital setting, the code for the CT of the thoracic spine may also be assigned, however modifier -52 should be appended to the code. This recommendation was made by the AMA and ACR in the Spring 2006 issue of Clinical Examples in Radiology. The rationale for appending the -52 for hospital billing is that there is lesser work in creating the reconstructed images, than having the patient back for a separate exam.

*Reference: Clinical Examples in Radiology, Volume 2, Issue 2; Spring 2006*

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### 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

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

## CMS Resources - 2009 MPFS Proposed Rule

**[Read Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009](#)**

## 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](http://www.seradmgt.com)

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