
Southeast Radiology Management e-News
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Head & Neck Angiography - Part 2

In our last issue, we provided a couple of case studies to test your knowledge of the coding principles discussed in the past several issues of our newsletter. How did you do?

In this issue we are providing two additional head and neck case studies to practice your coding skills. In our next issue, we will discuss coding for upper extremity angiography.

Remember to refer back to the newsletters from July 3, July 23, and August 25 for an explanation of key terms and coding rules.

<http://www.seradmgt.com/Archives.html>

Here are 2 cases to illustrate coding conventions for head and neck procedures. The following cases have been provided for you to practice your coding skills. ***At the end of the cases a link has been provided to the answers as well as an explanation of the answers for each case.***

Let's Code!

CASE 1

Reasons for examination: Left internal carotid artery aneurysm; left cerebral hemispheric hemorrhagic infarct.

PROCEDURE:

Following sterile preparation, draping, and local anesthetic administration, access was gained at the right common femoral artery, and a sheath was placed. Through this, a berenstein catheter, which was used for performing selective right common carotid, selective right internal carotid, selective left common carotid, and selective left internal carotid angiograms, with cervical and intracranial views of all vessels. Following completion of the procedure, the catheters and sheaths were removed, and hemostasis was obtained with a StarClose device. The patient tolerated the procedure, and there were no immediate complications. In spite of sedation by the ICU service, the exam is mildly limited due to patient motion artifact.

FINDINGS:

Right carotid bifurcation angiogram demonstrates no atherosclerotic disease. There is no stenosis. There is no evidence of dissection or ulceration. There is patent flow in the upper cervical internal carotid artery. The external carotid artery is patent. Cerebral angiogram from the right internal carotid injection demonstrates filling of the right anterior, middle, and posterior cerebral circulation vessels, with no evidence of stenosis or aneurysm. There is no

vascular malformation. There is some filling of the left anterior cerebral artery.

Left carotid bifurcation angiogram demonstrates no atherosclerotic disease. There is 0% stenosis. There is no evidence of dissection or ulceration. There is patent flow in the upper cervical left internal carotid artery. The external carotid artery is patent. Cerebral angiogram from the left internal carotid ejection demonstrates a large irregular saccular aneurysm is evident arising from the distal left internal carotid artery. This arises in the supraclinoid portion of the left internal carotid artery prior to its terminus. This large aneurysm extends medially into the suprasellar space.

It is multi-lobed consistent with its acute rupture. It measures up to 1.6 cm in greatest diameter. A discrete neck is difficult to discern. There is narrowing of the terminal left carotid artery, prior to the aneurysm. There is also narrowing of the carotid artery just beyond the aneurysm but prior to the MCA/ACA bifurcation. Moderate stenosis of the left mid MCA is also noted with diminished and mildly delayed filling of the MCA distribution. There is also (mild) narrowing of the left A2 segment, although there is filling of the more distal branches. Lenticulostriate arteries noted to fill. The vertebral arteries were not evaluated because they were evaluated on the prior CTA.

IMPRESSION:

Large multi-lobed aneurysm of the left supraclinoid carotid. A discrete aneurysm neck is difficult to identify. Moderate stenosis of the carotid immediately proximal and distal to the aneurysm noted with stenosis (mid M1) and diminished filling of the MCA distribution, perhaps due to degree of cerebral edema, although vasospasm cannot be excluded. Additional aneurysm in the left MCA distribution difficult to entirely exclude due to diminished filling and patient motion, although none is evident, even on fairly high quality rotational imaging.

CASE 2

Reasons for examination: Intracranial hemorrhage

After patient interview and examination, and discussion of risks, benefits, and alternatives to the procedure, informed consent was obtained for the procedure and for conscious sedation.

PROCEDURE: Following sterile preparation, draping, and local anesthetic administration, access was gained at the right common femoral artery, and a sheath was placed. Through this, an HI catheter, which was used for performing selective right common carotid, selective right internal carotid, selective right vertebral, and selective left vertebral angiograms, with multiple views of all vessels. The catheter was then switched for a 5-French HN5 catheter which was used for performing selective left common carotid and selective left internal carotid cerebral angiograms. Following completion of the procedure, the catheters and sheaths were removed, and hemostasis was obtained with a star close device. The patient tolerated the procedure, and there were no immediate complications.

FINDINGS: Right carotid bifurcation angiogram with the catheter tip in the right common carotid artery demonstrates no significant atherosclerotic disease.

There is 0% stenosis. There is no evidence of dissection or ulceration. There is patent flow in the upper cervical internal carotid artery. The external carotid artery is patent.

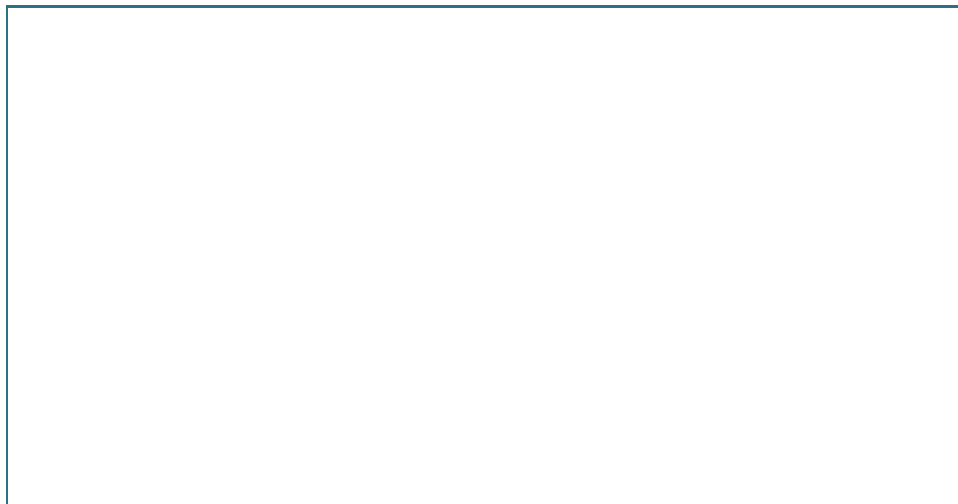
Right cerebral angiograms with the catheter tip in the right internal carotid artery demonstrate filling of the right anterior and middle cerebral circulation vessels, with a 3 x 3 x 5 mm long distal right M1 aneurysm, pointing inferiorly. There is no evidence of stenosis. There is no vascular malformation. Right vertebral angiogram was performed with the HI catheter tip in the cervical right vertebral artery, demonstrates a normal appearance of the right cervical vertebral artery. There is no stenosis or dissection. There is patent flow to the basilar artery. There is no aneurysm or vascular malformation.

Left vertebral angiogram performed with the catheter tip in the left cervical vertebral artery demonstrates a normal appearance of left cervical vertebral artery. There is no stenosis or dissection. There is patent flow to the basilar artery. The basilar artery has no significant stenosis. There is normal branching. There is no evidence of aneurysm or vascular malformation. Left carotid bifurcation angiogram was performed with the HN5 catheter tip in the left common carotid artery, demonstrates no significant atherosclerotic disease. There is 0% stenosis. There is no evidence of dissection or ulceration. There is patent flow in the upper cervical left internal carotid artery. The external carotid artery is patent. Cerebral angiogram performed with the HN5 catheter tip in the left internal carotid artery demonstrates filling of the right and left anterior, and left middle cerebral circulation vessels. There is a 3 x 3 x 3 mm aneurysm at the anterior communicating artery origin, arising more from the base of a dominant left A1 vessel, projecting anteriorly and towards the right. The neck is approximately 3 millimeters wide. Additionally, there is a proximal left M1 occlusion. Some patent flow is seen in an anterior division MCA branch. There are cortical collaterals from the left anterior cerebral into the MCA distribution. There is no vascular malformation.

IMPRESSION:

3 x 3 x 3 mm anterior communicating artery aneurysm. This is supplied by the left A1, which is dominant, and it projects anteriorly and towards the right. Proximal left M1 occlusion. Distal right M1 segment 3 x 3 x 5 mm aneurysm pointing inferiorly.

Go to <http://www.seradmgt.com/Answers> for the answers.



Question & Answer

I am confused as to when it is appropriate to report codes for duplex scans performed in conjunction with conventional ultrasound. I know that both exams should be ordered with the medical necessity for each documented, but what documentation should I look for in the report to code for a duplex scan?

First let's take a look at what CPT has to say about these exams--

In the Radiology section CPT states: "Evaluation of vascular structures using both color and spectral Doppler is separately reportable. To report, see Noninvasive Vascular Diagnostic Studies (93875-93990). However, color Doppler alone, when performed for anatomic structure identification in conjunction with a real-time ultrasound examination, is not reported separately."

In the Medicine section CPT states: "Duplex scan (eg, 93880, 93882) describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries or veins with the production of real-time images integrating B-mode two-dimensional vascular structure, Doppler spectral analysis, and color flow Doppler imaging."¹

The ACR's Economics Committee on Coding & Nomenclature and the ACR's Economics Committee of the Commission on Ultrasound have taken the position that to assign these codes both spectral and color Doppler should be performed.²

True vascular analysis must be performed--use of Doppler simply to determine whether or not a structure is vascular does not constitute vascular analysis. A full and complete color Duplex with waveform analysis must be performed.

In the Ultrasound Coding User's Guide ACR specifically states "Assessing flow with color, recording a waveform and reporting the findings in a medically indicated examination are the key elements to look for in a report."

In the report you should see documentation of the velocity measurements of blood flow or you might see phrases such as "waveform normal", "spectral Doppler showed no flow" or "normal triphasic waveform patterns using Doppler interrogation".

¹ CPT 2008, Professional Edition, American Medical Association

² 2006 Ultrasound Coding User's Guide, American College of Radiology

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

2009 OIG Work Plan now available!

<http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf>

Items related to radiology services:

- *Payments for Diagnostic X Rays in Hospital Emergency Departments
- *Place of Service Errors
- *Evaluation and Management Services During Global Surgery Periods
- *Geographic Areas With a High Density of Independent Diagnostic Testing Facilities
- *Patterns Related to High Utilization of Ultrasound Services
- *Physician Reassignment of Benefits
- *Medicare Billings With Modifier GY

GAO Report Released - Medicare: Trends in Fees, Utilization, and Expenditures for Imaging Services Before and After Implementation of the Deficit Reduction Act of 2005

<http://www.gao.gov/new.items/d081102r.pdf>

CMS Resources

Medicare Publishes Billing Edits to Reduce Payment Errors

The Centers for Medicare & Medicaid Services today announced that, beginning October 1, 2008, it will publish most of the edits utilized in its Medically Unlikely Edit (MUE) program to improve the accuracy of claims payments.

http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

PQRI Portal

The Centers for Medicare and Medicaid Services (CMS) is pleased to announce that a new self-service look-up tool is now available on the PQRI Portal at <http://www.qualitynet.org/pqri> <http://www.qualitynet.org/pqri> on the Internet, which allows an eligible professional at the Tax Identification Number (TIN) level to see if their 2007 PQRI Feedback Report is available.

Medlearn Matters

MM6169 - Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 14.3, Effective October 1, 2008

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6169.pdf>

MM6129 - New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6129.pdf>

SE0832 - The ICD-10 Clinical Modification/Procedure Coding System (CM/PCS)-The Next Generation of Coding

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf>

Register for our Interventional Radiology Coding Seminar!

Master interventional radiology coding with the 2 1/2 day hands-on interactive workshop presented by Stacie L. Buck, RHIA, CCS-P, LHRM, RCC, CIC

October 29-31, 2008
Double Tree Hotel
Palm Beach Gardens, Florida

This program has been accepted by the **Radiology Coding Certification Board** for 15 hours of continuing education credits towards RCCB recertification.

This program has prior approval of the **American Academy of Professional Coders** for 15.0 Continuing Education Units.

[Click here for agenda, pricing and registration.](#)

Register for one or more of our upcoming IR webinars!

October 7, 2008
Interventional Radiology: Upper Extremity, Lower Extremity & Pelvic Angiography
<http://www.knowledgeconnex.com/SRM/Webinar.asp>

October 21, 2008
Interventional Radiology: Abdominal Angiography
<http://www.knowledgeconnex.com/SRM/Webinar.asp>

November 4, 2008
Interventional Radiology: Angioplasty, Stents & Atherectomy
<http://www.knowledgeconnex.com/SRM/Webinar.asp>

November 18, 2008
Interventional Radiology: Embolization, Occlusion, Thrombolysis, Dialysis Access Maintenance
<http://www.knowledgeconnex.com/SRM/Webinar.asp>

December 2, 2008
Interventional Radiology: IR Case Studies
<http://www.knowledgeconnex.com/SRM/Webinar.asp>

Each program has been accepted by the **Radiology Coding Certification Board** for 2 hours of continuing education credits towards RCCB recertification.

Each webinar session has prior approval of the **American Academy of Professional Coders** for 2.0 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the Academy of the program, content or the program sponsor.

[Click here for agenda, pricing and registration.](#)

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>

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Let Us Know What You Think!

We want to make sure that the information that we provide to you is relevant and timely. Please feel free to share comments and suggestions with us about our e- News.

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