# CMS Withdraws CCI Policy Change

The Correct Coding Initiative policy decision is good news for endovascular physicians.

**BY JACKIE MILLER, RHIA, CPC**

The Correct Coding Initiative (CCI) edits are used by Medicare and certain other payors to bundle procedures that should not have been billed separately. There are edits for both physician services and hospital outpatient services.

The CCI edits are based on principles outlined in the Centers for Medicare and Medicaid Services (CMS) *National Correct Coding Initiative Policy Manual for Medicare Services*.[1] Most of the information in the manual is consistent with existing Current Procedural Terminology (CPT) coding guidelines.

In the fall of 2007, important new language regarding endovascular procedures was added to the CCI manual. According to the medical director of the National Correct Coding Initiative (NCCI), the revision was made in response to "an inquiry from a physician who teaches interventional vascular coding."[2] The new guidance appeared in chapter 5 of version 13.3 of the manual, which became effective October 1, 2007. It states:

> If an atherectomy fails to adequately improve blood flow and is followed by an angioplasty at the same site/vessel during the same patient encounter, only the successful angioplasty may be reported. Similarly, if an angioplasty fails to adequately improve blood flow and is followed by an atherectomy at the same site/vessel at the same patient encounter, only the successful atherectomy may be reported. If atherectomy and/or angioplasty fail to adequately improve blood flow and are followed by a stenting procedure at the same site/vessel during the same patient encounter, only the successful stenting procedure may be reported. These principles apply to percutaneous or open procedures.

The new language had the effect of prohibiting physicians and hospitals from reporting more than one intervention (angioplasty, atherectomy, or stent placement) in a single peripheral vessel. Although the CMS Web site indicates that its coding policies are based on CPT coding conventions and "coding guidelines developed by national societies," the new CCI manual language contradicted many years of official guidance from the American Medical Association and other professional societies. The concept of reporting multiple interventions has been supported in published American Medical Association guidance going back to 1993,[3] as well as in the *Interventional Radiology Coding Users' Guide* published by the Society of Interventional Radiology.

> "In response to the protests from physicians, CMS plans to rescind the policy change and revert back to the much more limited guidance that was published in the manual previously."

CMS did not solicit input from the specialty societies prior to making the revision to the CCI manual; the change was not effectively publicized, and the new manual language was not accompanied by any new bundling edits. Although the manual stated that only one intervention could be reported per vessel, the CCI edits did not bundle the codes for the interventions with each other.

As the provider community became aware of the new manual language, there was an outpouring of frustration that such a major change was made without advance notice, without input from physician specialty societies, and in contradiction to long-standing coding conventions. A letter written jointly by the American College of Cardiology, the American College of Radiology, the Society for Cardiac Angiography and

Interventions, the Society for Vascular Surgery, and Society of Interventional Radiology stated, "This unannounced disruption of established reporting conventions has left thousands of providers questioning how to correctly report procedures they do every day."[4]

In response to the protests from physicians, CMS plans to rescind the policy change and revert back to the much more limited guidance that was published in the manual previously. The corrected policy will appear in the version of the *NCCI Manual*, which is effective October 1, 2008, but it will be retroactive to October 1, 2007.

The previous version of the manual dealt only with angioplasty and atherectomy. It reads:

> When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty only, only the most comprehensive atherectomy that was performed (generally the open procedure) is reported.

This policy affects only angioplasty followed by atherectomy, rather than any combination of interventions.

## CONVENTIONAL GUIDELINES

Based on established CPT coding conventions, as well as the language that will be restored to the CCI manual retroactive to October 1, 1997, the following guidelines should be used when multiple interventions are performed in the same vessel:

1. Angioplasty performed to deploy a stent is included in the stent placement and should not be separately coded. This includes use of a balloon to predilate the vessel or to expand the stent. Only the stent placement should be coded in this situation.
2. When primary angioplasty is attempted, but results are unsatisfactory and therefore a stent must be placed, code both the angioplasty and the stent placement. The procedure note must indicate the attempted angioplasty and the unsatisfactory result (preferably with documentation of the degree of residual stenosis). If the physician does not expect to treat the lesion by angioplasty alone (eg, ostial renal artery stenosis), the angioplasty should not be separately coded.
3. When angioplasty and stent placement are used to treat separate lesions in a single vessel, code both procedures. The procedure note must indicate the location of the separate lesions and the treatment that was used on each.
4. When stent placement results in a complication such as dissection, and angioplasty is used to treat the complication, code both procedures.
5. When atherectomy is performed to prepare a vessel for planned angioplasty or planned stent placement, code only the planned procedure.
6. When primary atherectomy is attempted but results are unsatisfactory (eg, there is an area of underlying stenosis revealed once the plaque is removed) and stent placement or angioplasty is performed, code both the atherectomy and the stent placement or angioplasty. However, the procedure note must describe the attempted atherectomy and the unsatisfactory results.
7. Per the *CCI Policy Manual*, if angioplasty is followed by atherectomy due to unsatisfactory results, only the atherectomy should be coded. Note that this is a Medicare guideline and does not necessarily apply to other payors.

When performing multiple interventions, it is extremely important to document the specific lesions that were treated, the interventions that were performed, and the reason why the additional interventions were necessary. Documenting the rationale for the treatment will assist coding staff in submitting a correct claim and will help to prevent retrospective denials in the event of a payor audit.

## EXAMPLES

The following are several examples of correct coding for multiple interventions. The grid for each example shows the codes that would have previously been assigned under the restrictive CCI language that has now been repealed, as well as the codes that should be assigned currently under CPT coding conventions.

Note: The relative value units (RVUs) in Tables 1 through 3 are the 2008 Medicare RVUs for procedures performed in a hospital setting. The total RVUs for each case reflect 50% discounting for secondary surgical component codes.

**Scenario No. 1**

The patient has a left superficial femoral artery (SFA) stenosis found on a prior arteriogram. Angioplasty of the left SFA is performed from right femoral access. Due to significant residual stenosis, a stent is placed in the left SFA (Table 1).

**Scenario No. 2**

The patient has a left SFA stenosis found on prior arteriogram. Atherectomy of the left SFA is performed from right femoral access. Due to significant residual stenosis, a stent is placed in the left SFA (Table 2).

| TABLE 1. SCENARIO No. 1* | | | | |
|---|---|---|---|---|
| | CCI Restrictions | | Coding Conventions | |
| Procedure | Code | RVUs | Code | RVUs |
| Stent placement, left SFA | 37205 | 12.37 | 37205 | 12.37 |
| Stent placement S&I | 75960-26 | 1.17 | 75960-26 | 1.17 |
| Angioplasty, left SFA | n/a | n/a | 35474 | 10.86 |
| Angioplasty S&I | n/a | n/a | 75962-26 | 0.76 |
| Third-order catheter placement | 36247 | 9.01 | 36247 | 9.01 |
| Total RVUs | | 18.05 | | 24.24 |
| *S&I indicates supervision and interpretation.* | | | | |

| TABLE 2. SCENARIO No. 2 | | | | |
|---|---|---|---|---|
| | CCI Restrictions | | Coding Conventions | |
| Procedure | Code | RVUs | Code | RVUs |
| Stent placement, left SFA | 37205 | 12.37 | 37205 | 12.37 |
| Stent placement S&I | 75960-26 | 1.17 | 75960-26 | 1.17 |
| Atherectomy, left SFA | n/a | n/a | 35493 | 12.53 |
| Atherectomy S&I | n/a | n/a | 75992-26 | 0.78 |
| Third-order catheter placement | 36247 | 9.01 | 36247 | 9.01 |
| Total RVUs | | 18.05 | | 25.18 |

| TABLE 3. SCENARIO No. 3 | | | | |
|---|---|---|---|---|
| | CCI Restrictions | | Coding Conventions | |
| Procedure | Code | RVUs | Code | RVUs |
| Stent placement, left SFA | 37205 | 12.37 | 37205 | 12.37 |
| Stent placement S&I | 75960-26 | 1.17 | 75960-26 | 1.17 |
| Atherectomy, left SFA | n/a | n/a | n/a | n/a |
| Atherectomy S&I | n/a | n/a | n/a | n/a |
| Third-order catheter placement | 36247 | 9.01 | 36247 | 9.01 |
| Total RVUs | | 18.05 | | 18.05 |

**Scenario No. 3**

The patient has a left SFA stenosis found on prior arteriogram. Stent placement is planned. Atherectomy of the left SFA is performed from right femoral access to remove overlying plaque. A stent is then placed in the left SFA (Table 3). ■

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1. National Correct Coding Initiatives Edits overview page. Centers for Medicare and Medicaid Web site. Available at http://www.cms.hhs.gov/NationalCorrectCodInitEd/. Accessed September 24, 2008.
2. Rosen N. Letter to the American College of Cardiovascular Administrators. August 27, 2008.
3. Component Coding of Interventional Radiology Services: Why and How. CPT Assistant. Fall 1993. Page 11.
4. Wallis D, Blankenship J, Duszak R, et al. Letter to Niles Rosen, MD. February 22, 2008. Available at http://64.233.169.104/search?q=cache:cCHDPRKr_b8J:members.sirweb.org/members/coding/NCCI_appeal.pdf+Niles+Rosen,+MD+letter+ACC+2008&hl=en&ct=clnk&cd=2&gl=us. Accessed September 24, 2008.