Principles of Endovascular Coding

What you don't know about coding is just as important as what you do know.

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In an effort to keep readers informed of pertinent issues relating to coding and billing, Endovascular Today *will now be providing a semiregular forum in which experts discuss perennially difficult components of the current system and updates that emerge in the future. If there is a specific topic you would like one of the authors to cover, please contact us at evteditorial@bmctoday.com.*

Endovascular procedures are typically coded with component codes rather than the more typical "bundled" codes used for open vascular surgical procedures. The component coding system was developed to allow flexibility for coding large numbers of procedures that can be performed in multiple combinations and by a variable number of physicians, without having thousands of specific codes to describe all the possible permutations.

Endovascular coding principles are similar across all specialties providing endovascular services. In most cases, coding for a particular procedure will be the same, independent of whether it is performed by an interventional radiologist, cardiologist, vascular surgeon, or other vascular specialist. There are some minor exceptions. One such exception is that some interventional codes are different if performed as an open procedure rather than a percutaneous procedure (noncoronary vascular stents, noncoronary peripheral artery PTA). For instance, a percutaneous stent placement for treatment of a common iliac origin stenosis done from the ipsilateral femoral approach would be coded as 37205, 36200, 75960. If the same procedure were done through an open femoral exposure rather than percutaneously, it would be coded as 37207, 36200, 75960 (the open femoral exposure would be coded as part of any other surgical procedure occurring at the same setting). Another exception to the rule that procedures are coded the same across specialties is that there is variation for some peripheral vascular diagnostic procedures when done in combination with a cardiac catheterization (G codes are used for renal angiography and iliac angiography when done in conjunction with a cardiac catheter).

To bill correctly, the coder must know the codes. Each code has a specific description, and one must understand what is included in the code and its valuation, as well as what is not. The most accurate coding is possible when the physician who performs the procedure does the coding, as long as he knows what each code describes.

CODING COMPONENTS

Most endovascular procedures have at least two components: the surgical component and the radiological component. The surgical part of the procedure is the actual "doing" part, including needle, catheter, wire placements, balloon-

ing, and stenting. The surgical component is coded typically with codes from the 30000 series of Current Procedural Terminology (CPT) codes. The radiological part of the procedure includes the imaging required to perform the surgical part, permanent recording of images, supervising the imaging portion of the procedure, and interpretation of the fluoroscopy and images. The radiological portion of the procedure is sometimes referred to as supervision and interpretation (S&I) or radiological supervision and interpretation (RS&I). The RS&I codes typically are found in the 70000 series of CPT.

Often, there are more than two codes needed to describe a procedure. There may be more than one surgical code, and there may be more than one RS&I code. In addition, there is often not a 1:1 correlation between surgical and RS&I codes; the surgical codes tend to have higher work values than the RS&I codes. The surgical codes are subject to the 50% multiple surgical reduction rule, whereas the RS&I codes are not. The result of the surgical reduction discount is that the highest value surgical code is paid at full value, while each additional surgical code is paid at 50% value.

For most interventional surgical codes, the work of access is not included in the surgical code, and is separately reported. (The access/catheterization codes for arterial procedures are typically described by 36200, 36140, 36145, 36215-8, 36245-8). This is true for interventions such as PTA, stenting, embolization, endovascular graft, and thrombolysis, for instance. If one does not code for the access with these procedures, one has missed a substantial amount of the work that was done.

In most instances, diagnostic procedures are not included in therapeutic procedures. If performed at the same setting, each should be coded (unless the diagnostic study is just being repeated for confirmation prior to the intervention, and there is a recent study with no interval clinical status change). When doing both diagnostic and therapeutic work at the same session, the access (catheterization) code is used only once for each access because the work of placing the catheter in its ultimate position is done just once. The component coding system is evolving, and refinements to improve the system are continuously being evaluated at the AMA CPT panel (where new codes are developed), at the AMA RUC panel (where new codes are valued), at CMS (Centers for Medicare & Medicaid Services), and at other carriers. With several new specialties now performing these procedures, the learning curve for billing and coding has not kept up with the performance of the procedures. Carriers are finding combinations of codes not previously seen or not previously seen so frequently, which attracts their attention and raises questions about the validity of the coding.

NEW NOMENCLATURE REQUIRES ACCURATE CODING

In addition, the OIG (Office of the Inspector General) has increasingly scrutinized medical billing. In 2002, CPT made a change in their nomenclature and instructions given in the CPT manual. CPT now instructs physicians to use the accurate code for billing their procedure, rather than the previous instruction to use the "closest available" or "approximate" code. This change in instruction may make fraud easier to determine.

In the past, as new procedures were developed, closest-available codes were sometimes used or suggested for use until a code specific for the new procedure was developed. This is no longer recommended. If there is not a specific code that describes exactly the procedure being performed, one should seek advice from their specialty society and/or local carrier. The specialty societies are putting more effort into developing helpful tools to use with local carriers to obtain payment for new procedures, bridging the inevitable gap between when a new technology is available and when a CPT code and payment policy is in place. Carriers do have the latitude in many instances to allow use of an existing CPT code that is not accurate, but one should get permission to do this in writing, and then keep this document on file as a record of the permission. Carriers often change directors, and they may not maintain a copy of this permission or have any memory of the agreement, and it is safest for the provider to keep this documentation on file. More typically, carriers will request use of an unlisted procedure code. These codes are designed specifically for this use. There is a series of codes in CPT, found in most sections, always ending in –99. These codes are not given relative value units (RVUs), but the local carrier may choose to assign RVUs for a particular procedure. This does not happen automatically, but working with the carrier to explain the procedure and its value can achieve a reasonable payment policy for an unlisted procedure code. The model policies put together by a national society will often include the explanation of the procedure and basic advice on valuation, allowing the physician or practice to personalize the policy and submit it to the local carrier.

When coding, it is important to code all services provided. Because of ever-changing rules, however, one must pay attention and make changes in billing accordingly. Reimbursement for a code does not mean that the code is accurate. Bills are subject to medical review by the carrier, and if the carrier finds that they have erroneously paid for a code deemed to be inappropriate or in error, they may request a refund at best, and at worst could find the provider guilty of fraud. While the provider has the opportunity to dispute the finding of the medical review, they

may ultimately be required to pay large sums of money back to the carrier, and may have no grounds for argument if they have used a code that is not accurate for a new procedure, even though they believe it closely approximates the services provided.

A recent trend in CPT coding is to develop some new endovascular codes as bundled codes rather than component codes (eg, TIPS, dialysis graft declotting). In the future, codes will be bundled when it makes sense from a clinical standpoint. Examples of this include (1) the entire procedure is always done by a single provider, always using the same steps, (2) the imaging that is performed is really incidental to the procedure being done, and (3) the procedure being carried out is really incidental to the imaging being done (eg, for an arthrogram, the joint injection is incidental to the imaging portion of the study).

In addition to being very familiar with the codes used, one also needs to be aware of CCI (Correct Coding Initiative) edits. CMS publishes these edits several times a year, identifying codes that are not properly billed together. Sometimes these are published in response to concern at CMS that the codes are being misused or abused. These edits may be relative or may be absolute. If they are relative, they may be overridden by a modifier in the appropriate circumstance. If they are absolute, they cannot be overridden in any manner. An example of a CCI edit is that 37207 (noncoronary vascular stent) may not be used together with an abdominal aortic endograft code. This is intended to prevent coding for a stent placed within an endograft to fully open or support the endograft. If the stent was placed inside the endograft, it should not be separately billed (even if performed by a second physician) because that work is included in the value of the endograft code. However, if the stent was placed in the external iliac artery, distal to the endograft and target treatment zone for the endograft, the stent may be separately billed because this work is not included in the work of the endograft repair. In that case, the code 37207-59 would be used, to denote that this work was separate and separately payable.

This article is intended to be a brief overview of the coding system used for endovascular procedures. Several resources are available to help one code correctly, including (1) AMA CPT of the current year, (2) Society of Interventional Radiology Coding Users' Guide, (3) Coding and Reimbursement seminars and workshops, including SIR's Coding Cybersession 1/15/2003, and (4) http://cms.hhs.gov/physicians. ■

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