Coding Updates for 2020

An overview of updates to endovascular and interventional CPT coding for your practice.

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This article describes coding changes for endovascular and interventional procedures that took effect on January 1, 2020.

KEY

- ▲ Designates an existing CPT code with new revisions in 2020
- ● Designates a new CPT code in 2020
- \+ Designates an add-on code that must be reported with the appropriate base code

ENDOVASCULAR REPAIR

Branched (bifurcated) endografts to repair iliac artery disease have been approved by the FDA, and the procedures to implant the devices are now sufficiently described in the literature to warrant category I CPT codes. The category III code that has previously described this service (0254T) has been deleted. Two new codes, 34717 and 34718, have been added, which describe placement of a bifurcated endograft in the common iliac artery with extensions into both the internal and external iliac arteries.

34717 is an add-on code reported when this service is performed at the time of aortic endograft repair (ie, at the time of placement of either an aorto-bi-iliac or aorto-uni-iliac device). The base codes for this add-on code are 34703, 34704, 34705, and 34706. Code 34717 is not reported with 34701 or 34702, which describe aorto-aortic tube endograft placement.

34718 is reported when this service is performed as a stand-alone procedure, either to repair isolated iliac disease as a separate procedure or to extend a previous endograft repair of the aortoiliac vessels at a separate setting. 34718 is not an add-on code. It cannot be reported with any other code for endograft placement, including codes for aorto-aortic tube endorepair.

Like other endograft codes, the new codes for branched iliac endograft placement include many of the procedural components. Preprocedural sizing and device selection are included and not separately reported. All iliac artery catheterizations for the ipsilateral side are included, regardless of entry site or approach. This includes all catheterizations of the aorta as well as the ipsilateral common, external, and internal iliac arteries. Any angioplasty or stenting performed in the treatment zone are included and not separately reported. Deployment of the device components, as well as any extensions placed in the ipsilateral common iliac, external iliac, or common femoral arteries are included (34709, 34710, 34711 are not reported for ipsilateral extensions of the branched iliac device). All angiography and radiologic supervision and interpretation are included.

Vessel access is not included and may be reported separately if a surgical exposure is required. 34713 may be separately reported with 34718 if percutaneous access is performed with a sheath ≥ 12 F.

Both codes (34717 and 34718) may be reported for repairs of aneurysm, pseudoaneurysm, dissection, arteriovenous (AV) malformation, and penetrating ulcer.

Code 34717 may be reported when repairing an acute rupture or for traumatic disruption of the vessel. 34718 cannot be reported when the procedure is performed for an acute rupture. Instead, unlisted code 37799 is reported when a branched iliac endograft is placed as a stand-alone procedure for an acute rupture.

Codes 34717 and 34718 specifically describe placement of branched devices. Although a "branched" type of device can be created using side-by-side stents or a chimney technique, these codes are not reported for placement of devices other than those designed as unique branched (bifurcated) endografts. Instead, arterial stent placement codes (37236 if treating aneurysmal disease, 37221 if treating concomitant occlusive disease)

would be used to report placement of a stent into the hypogastric artery at the time of iliac endograft placement when the hypogastric device is not a component of a specifically indicated branched device.

If 34717 is performed bilaterally, report code 34717 twice. If 34718 is performed bilaterally, report 34718 for the first procedure and 34718 with a −50 modifier for the contralateral procedure. This difference in reporting is because 34717 is an add-on code, already valued as an additional service and not subject to the 50% surgical reduction rule for surgical codes that are not add-on codes.

●+34717 Endovascular repair of iliac artery at the time of aortoiliac artery endograft placement by deployment of an iliac branched endograft including preprocedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiologic supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, AV malformation, penetrating ulcer, traumatic disruption), unilateral (list separately in addition to code for primary procedure)

●34718 Endovascular repair of iliac artery, not associated with placement of an aortoiliac artery endograft at the same session, by deployment of an iliac branched endograft, including preprocedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiologic supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, aneurysm, pseudoaneurysm, dissection, AV malformation, penetrating ulcer), unilateral

PERICARDIOCENTESIS

The code family for pericardiocentesis and pericardial drain placement is revised and updated for 2020. The previous codes (33010, 33011, and 33015) have been deleted. New codes 33016, 33017, 33018, and 33019 have been added to describe these services. Because imaging guidance is generally used to perform these procedures, the typical forms of imaging guidance are bundled into the codes.

Code 33016 describes pericardiocentesis and is reported for the service when any type(s) of imaging guidance is used and is also reported if no imaging guidance is used. 33016 is reported for drainage or sampling of fluid in the pericardium, whether performed via needle, catheter, or any type of tube that is removed at the completion of the pericardiocentesis.

Codes 33017, 33018, and 33019 describe pericardial drainage procedures. These codes are reported when a catheter is left in position for subsequent pericardial drainage (ie, the patient leaves the procedure room with a drainage catheter in place in the pericardium). These codes are not reported if a catheter or tube is temporarily placed in the pericardial sac for fluid drainage or sampling but is removed at the end of the procedure (instead, use 33016 if no drain is left in place). These codes include the typical types of imaging guidance used for pericardial drainage. 33017 and 33018 include fluoroscopic and/or ultrasound (US) guidance. 33019 specifically includes CT guidance with the placement of a pericardial drain. Additional guidance codes (77002, 77012, 77021, and 76942) cannot be reported with 33017, 33018, or 33019, even if additional modalities are used to complete the procedure. Echocardiography cannot be additionally reported to describe US guidance for pericardiocentesis or pericardial drainage. Echocardiography (93303–93325) may be reported additionally if a diagnostic echocardiogram is obtained and documented.

Codes 33017 and 33018 are distinguished based on two factors: (1) the age of the patient, and (2) the presence of a congenital cardiac anomaly. If the patient is ≤ 5 years, code 33018 is reported, even if there is no congenital cardiac anomaly. If there is a congenital cardiac anomaly, 33018 is reported regardless of the patient's age. If the patient is ≥ 6 years and does not have a congenital cardiac anomaly, 33017 is reported.

●33016 Pericardiocentesis, including imaging guidance, when performed

●33017 Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or US guidance, when performed, 6 years and older without congenital cardiac anomaly

●33018 birth through 5 years of age or any age with congenital cardiac anomaly

●33019 Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance

SPINAL PUNCTURE

The spinal puncture codes have been updated for 2020. Fluoroscopic and/or CT guidance have been bundled with the procedural codes and now cannot be separately reported. The existing codes 62270 and 62272 have been modified and are reported when fluoroscopic or CT imaging guidance is not used. Imaging guidance codes 77003 and 77012 cannot be reported separately with 62270 and 62272.

Codes 62383 and 62329 are new codes that bundle fluoroscopic and/or CT guidance with diagnostic or therapeutic spinal punctures. Imaging guidance codes 77003 (fluoroscopic guidance) and 77012 (CT guidance) cannot be separately reported with codes 62383 or 62389. However, if US or MR guidance is used for the diagnostic or therapeutic spinal puncture, 76942 (US guidance) or 77021 (MR guidance) may be separately reported with 62383 and 62329 if US and/or MR guidance are used in addition to fluoroscopic and/or CT guidance or may be reported with 62270 or 62272 if guidance is only provided using US and/or MR.

▲62270 Spinal puncture, lumbar, diagnostic

●62383 with fluoroscopic or CT guidance

▲62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)

●62329 with fluoroscopic or CT guidance

MODIFICATION OF EXISTING CODE 33725

Code 33275 was modified to clarify that imaging guidance is included in the service. The bolded language was added. The service described is not changed.

▲33275 Transcatheter removal of permanent leadless pacemaker, right ventricular, including **imaging guidance (eg, fluoroscopy, venous US, ventriculography, femoral venography), when performed**

PREOPERATIVE ASSESSMENT OF POTENTIAL HEMODIALYSIS ACCESS SITES

Two new codes are added to CPT in 2020 to replace G-codes previously used to describe duplex services for evaluation of arterial inflow and venous outflow prior to the creation of a new hemodialysis access.

●93985 Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study

●93986 complete unilateral study

To report these codes, complete assessment of both the arterial inflow and venous outflow for the extremity must be performed and reported. If only the arterial vessel(s) is assessed, the study is reported with 93930 or 93931 if the elements required to report those studies are performed and documented. If only a venous assessment is performed, codes 93970 or 93971 may be reported if all the necessary elements are performed and reported. Codes 93985 and 93986 do not include physiologic arterial evaluation of the extremity(s), and those services may be separately reported if indicated, performed, and documented.

PLACEMENT OF ILIAC AV ANASTOMOSIS IMPLANT

A new category III code has been added to describe percutaneous placement of an AV anastomosis implant. This is an investigational procedure to treat refractory hypertension and will probably be performed within an investigational study initially. Code 0553T is intended to be inclusive of the entire service, including catheterization of the iliac artery(ies) and veins, all procedural imaging and imaging guidance, creation of the AV fistula, angioplasty and/or stent placement in the iliac or femoral artery and/or vein, and placement of a device to maintain direct flow from the iliac artery to the iliac vein. US guidance for puncture of the artery and vein should not be separately reported.

●0553T Percutaneous transcatheter placement of iliac AV anastomosis implant, inclusive of all radiologic supervision and

interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention

CATEGORY III CODE FOR ISLET CELL TRANSPLANTATION

Three new codes for islet cell transplant have been added. Code 0584T describes the percutaneous procedure (0585T and 0586T describe the laparoscopic and open procedures, respectively).

●0584T Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiologic supervision and interpretation, when performed; percutaneous

The service includes portal vein catheterization from any approach, all diagnostic imaging and imaging guidance, as well as infusion of islet cells.

CATEGORY III CODES FOR TRANSCATHETER VALVE REPAIR

Several new category III codes were added for new technology for heart valve repair. Right and left heart catheterization intrinsic to the valve repair procedure is included in these codes and is not separately reported. Diagnostic coronary angiography is not separately reported when performed as confirmatory information of previous studies or when used for roadmapping, procedural guidance, completion angiography, or for measurements.

Codes 0544T, 0545T, 0569T, and 0570T include vascular access, cardiac catheterization, deployment, and any adjustment of the device(s)and access vessel closure. Temporary pacemaker insertion for rapid pacing is included when performed with 0544T and 0545T and is not separately reported.

Intracardiac echocardiography is not reported separately with 0569T or 0570T, but transesophageal echocardiography may be separately reported if performed and documented.

●0544T Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture

●0545T Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach

●0569T Transcatheter tricuspid valve repair, percutaneous approach, initial prosthesis

●+0570T each additional prosthesis during same session ■

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Disclosures: None.