Coding Changes for 2013

Several families of codes for endovascular/interventional procedures have changed as part of the AMA's ongoing effort to bundle and reassess relative valuation of all CPT codes.

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As mandated by the Affordable Care Act, the Current Procedural Terminology (CPT) and Relative Value Update Committee (RUC) Panels of the AMA have continued to review large numbers of existing CPT codes for potential misvaluation with the intent to bundle work/procedures into as few codes as possible. As a result, there are several coding changes that became effective January 1, 2013, which will be discussed in this article. For endovascular codes, the major review of existing codes should be completed, and the last major revisions are expected to be effective by January 1, 2014.

As your societal CPT advisors and the CPT Panel craft new bundled codes, efforts are made to be as consistent as possible throughout the entire code set with respect to the aspects of the procedures that are bundled into a code. The overarching principle for bundling, however, is to include those portions of the procedure that are reproducibly performed in almost all procedures reported by the specific CPT code. If there are portions of the procedure that are too variable to predict for the majority of procedures, those portions of the procedure will likely be reported with an additional code.

The new codes to be discussed in this article include eight bundled codes for diagnostic cervicocerebral angiography, one new code for intravascular foreign body retrieval (FBR), four new bundled codes for thrombolysis, four new codes for thoracentesis/chest drain placement, and new codes for renal denervation.

CERVICOCEREBRAL ANGIOGRAPHY

The entire set of codes used to report cervicocerebral angiography has been revised. The RS&I (radiological supervision and interpretation) codes previously used to report these services have been deleted from CPT (75650, 75660, 75662, 75665, 75671, 75676, 75680) and are no longer available for use. The selective catheterization codes previously used to report these services (36215–36218, 36200) remain active but will no longer be used to report cervicocerebral angiography.

The new set of codes for cervicocerebral angiography includes eight new bundled codes (36221–36228) (Table 1). Each code includes catheterization of the vessel, all imaging required for the procedure, interpretation of the imaging, and supervision of the procedure. Codes 36221–36226 also include moderate sedation and closure of the puncture. Because 36227 and 36228 are add-on codes, the sedation and puncture closure are not considered part of the work of these two codes. These new bundled codes are based on the name of the vessel selected, eliminating the need to determine the degree of selective catheterization in order to decide on the appropriate code to report.

Because +36227 (selective external carotid angiography) and +36228 (superselective intracranial angiography) are both add-on codes, they must be reported with a base code. In order to report external carotid angiography or intracranial superselective angiography, one must also perform and report selective diagnostic angiography of at least the common carotid artery (or vertebral artery if 36228 is performed in intracranial vertebral branches) on the same side.

The cervicocerebral angiography codes are built on hierarchies, with each hierarchical increase signified by a higher degree of selectivity of catheterization resulting in more detailed imaging. They include the work of the lesser hierarchical codes (when performed), as well as the work of the specific code (eg, 36222 < 36223 < 36224; 36225 < 36226). In other words, any imaging of the aortic arch and more proximal portions of the vessel(s) is included in codes describing angiography of distal portions of the vasculature. Only one of these codes may be reported per side for ipsilateral carotid angiography and only one of these codes per side for ipsilateral vertebral angiography.

If identical procedures are performed bilaterally (eg, bilateral intracranial carotid angiography performed via

TABLE 1. CERVICOCEREBRAL ANGIOGRAPHY

Abbreviated Partial Description	CPT Code
Nonselective catheterization of the thoracic aorta with nonselective contrast injection into the aorta for imaging of the intra- and/or extracranial carotid(s)/vertebral(s), including arch aortography if also performed	36221
Selective catheterization of common carotid or innominate artery (unilateral), with selective injection of contrast for imaging of the ipsilateral extracranial carotid (includes arch if also studied)	36222
Selective catheterization of common carotid or innominate artery (unilateral), with selective injection of contrast for imaging of the ipsilateral intracranial carotid circulation (includes ipsilateral extracranial carotid and arch if also studied)	36223
Selective catheterization internal carotid (unilateral), with selective contrast injection for imaging of the ipsilateral intracranial carotid circulation (includes ipsilateral extracranial carotid and arch if also studied)	36224
Selective catheterization subclavian or innominate (unilateral), with selective contrast injection for imaging of the ipsilateral vertebral circulation (includes arch if also studied)	36225
Selective catheterization vertebral (unilateral), with selective contrast injection for imaging of ipsilateral vertebral circulation (includes arch and proximal anatomy if also studied)	36226
Selective catheterization, external carotid artery (unilateral), with selective contrast injection for imaging of the ipsilateral external carotid circulation (report in conjunction with 36222, 36223, or 36224). This code includes any and all selective catheterizations/injections/diagnostic angiography within the ipsilateral external carotid artery circulation. Code 75774 is not reportable for additional supraselective catheterizations of ipsilateral ECA branches.	+36227
Selective catheterization, each intracranial branch of the internal carotid or vertebral arteries (unilateral), with superselective contrast injection for imaging of the selected vessel circulation (eg, middle cerebral artery, posterior inferior cerebellar artery) (report in conjunction with 36224 or 36226). Reporting limited to two times per side (right or left), regardless of the number of intracranial branches selected in the internal carotid and vertebral circulations.	+36228

bilateral common carotid injections), the correct CPT code should be reported with a -50 modifier (signifying a bilateral procedure). If bilateral angiography is performed, but the procedures are not identical (for instance, right carotid angiography was performed with a common carotid selection, but left carotid angiography was performed with an internal carotid selection), a -59 modifier would be attached to the right carotid angiography code, signifying that it was performed on the opposite side and designating that the two codes are not being reported for a single side. The -59 modifier should be used with the lower hierarchical code in these instances. CMS initially did not recognize bilateral procedures for cervicocerebral angiography but has recently resolved this error.

If diagnostic angiography is performed at the same time as an interventional procedure, one must be careful to consider what work is included in the diagnostic study so that work will not be reported twice. In general, this pertains mostly to the work of selective catheterization, but it is now very important to understand what is included in both the diagnostic code(s) and the interventional code(s) so that all the work is reported but the same work is not reported multiple times.

FOREIGN BODY RETRIEVAL (FBR)

A new bundled code for percutaneous transcatheter retrieval of intravascular foreign body (37197) was introduced in 2013. This code bundles the surgical portion of the retrieval procedure with the radiological supervision and interpretation of FBR. Selective catheterization is not included in the work described by 37197 and is reported separately. The old FBR codes, 37203 and 75961, have been deleted. Even though FBR codes were used to report inferior vena cava (IVC) filter retrieval/removal procedures in the past, code 37197 would not be used to report removal/retrieval of an IVC filter, since a specific code for IVC filter removal (37193) became effective in 2012 and should be used for this procedure.

THROMBOLYSIS

New codes (37211–37214) (Table 2) that bundle the surgical and radiological portions of thrombolysis were introduced in January 2013. These codes are unique in that they are the first endovascular codes to include all of the associated evaluation and management (E/M) related to the work of the procedure for that date. For instance, ongoing dosing of the lytic drug, phone calls

TABLE 2. THROMBOLYSIS	
Abbreviated Partial Description	**CPT Code**
Arterial thrombolytic infusion, initial treatment day. This code includes all the work of thrombolysis for the first day, even if the patient returns to the lab for additional imaging/catheter adjustment one or more times during the same calendar date.	37211
Venous thrombolytic infusion, initial treatment day. This code includes all the work of thrombolysis for the first day, even if the patient returns to the lab for additional imaging/catheter adjustment one or more times during the same calendar date.	37212
Arterial or venous thrombolytic infusion, subsequent day (includes all follow-up angiography, catheter exchange and/or repositioning). This code is reported once per date, even if the patient returns to the lab for follow-up imaging, catheter exchanges multiple times.	37213
Cessation of thrombolysis (arterial or venous) including removal or catheter and vessel closure (final day of thrombolytic medication). This code is reported for the final day of thrombolytic therapy, regardless of whether additional imaging was performed before the decision to stop treatment was made. If there are session(s) of follow-up angiography and/or catheter exchange during the same calendar date, that work is included in the work of this code. This code also includes any potential follow-up directly related to thrombolysis of the patient on that date (eg, puncture site evaluation/complication, reassessment of limb). If the final day of lytic therapy is the same as the initial day of therapy, one would report the appropriate initial day code and not 37214.	37214

TABLE 3. THORACENTESIS/CHEST TUBE PLACEMENT	
Abbreviated Partial Description	**CPT Code**
Thoracentesis (performed via needle or catheter), without imaging guidance	32554
Thoracentesis (performed via needle or catheter), with imaging guidance	32555
Pleural drainage with placement of indwelling drain, without imaging guidance	32556
Pleural drainage with placement of indwelling drain, with imaging guidance	32557

to nursing, bedside assessments of the patient, and patient pain management would be types of E/M work included in these new thrombolysis codes. If an E/M evaluation to assess the patient prior to the procedure is performed and documented and the decision to treat the patient is made based on that E/M, this E/M service may be separately reported using a -57 modifier (decision-to-treat modifier). Selective catheterization is not included in these codes and is separately reported. Ultrasound guidance for puncture access is also not included in the work of these codes and may be separately reported. The former code for thrombolysis (37201) has been deleted from CPT. (Extensive introductory language on page 218 of the 2013 CPT Manual provides overview.)

The new lysis codes state that they include thrombolysis performed "by any method." This includes all current methods of pharmacological thrombolysis such as infusion, pulse spray using various devices or hand-pulsed, or other devices designed to resolve thrombus through thrombolysis rather than mechanical thrombectomy. If mechanical thrombectomy is also used, it may be separately reported. The new set of lysis codes would not be used to report a bolus administration of a thrombolytic drug or use of a lytic drug in conjunction with a primarily mechanical device. Diagnostic angiography and other interventions such as angioplasty/stenting/atherectomy are also separately reported when performed and documented.

The thrombolysis codes may be reported for bilateral fields by using the bilateral modifier (-50) when performed through separate vascular punctures. CMS has determined that the thrombolysis codes may only be reported once per day; however, this means that if more than one field is treated but it is not bilateral, CMS will likely not recognize the second area of treatment (eg, superior mesenteric artery embolus and lower extremity embolus).

If the patient develops a new, unrelated medical problem during the course of thrombolysis (eg, chest pain), E/M services to evaluate and determine the course of treatment or consultation would be reported with the appropriate E/M code, appended with a -25 modifier (significant, separately identifiable E/M service provided on the same day of a procedure).

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RENAL DENERVATION

New category III codes for renal denervation (unilateral and bilateral) will be posted on the AMA Early Release website on July 1, 2013, and will be available for use at that time. These codes will be published in the 2014 CPT Manual. Providers performing these procedures should check with carriers before using the category III codes but should expect to begin using these once released in July.

THORACENTESIS/CHEST TUBE PLACEMENT

There are four new codes in 2013 for reporting thoracentesis and percutaneous chest tube (drainage catheter) placement (32554–32557) (Table 3). In CPT 2013, there is a parenthetical instruction that directs one to not report the new codes for thoracentesis and chest tube placement (32554–32557) with code 32550 (placement of a tunneled pleural drainage catheter). This was intended to pertain to procedures performed on the ipsilateral side but may have unintended consequences of not being paid if a drainage is performed on the contralateral side. This issue has been taken back to CPT to amend the parenthetical instruction and resolve this issue.

Codes 32556 and 32557 would be used for percutaneous placement of drainage catheters/chest tubes for treatment of pneumothorax, effusion, or empyema regardless of the size of the tube placed. Code 32551 describes "open" placement of a chest tube and was defined by the surgeons as requiring an incision and placement of a finger/thumb into the pleural cavity to dissect tissue for subsequent tube placement.

SUMMARY

Several new/revised codes were introduced in 2013 that are of interest to interventionists. These codes all involve bundling of at least some of the services previously reported with component codes. It is essential to understand what work is included in each code in order to correctly report and bill procedures performed. Bundling of the cervicocerebral angiography codes has raised questions about correct billing when performed at the same time as head/neck interventions, and further clarifying instruction is expected on this aspect within the next few weeks. The thrombolysis codes are unique because they include significant E/M work performed on the same day, a new concept for interventional coding. ■

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