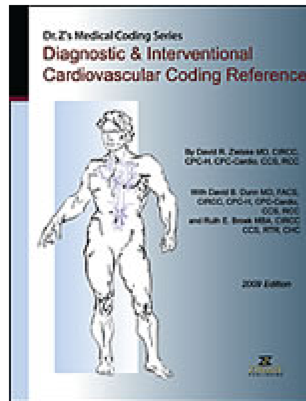

Dr Z’s Medical Coding Series: Diagnostic & Interventional Cardiovascular Coding Reference: 2009 Edition

2009 Book Errata

Page 310
CODES

Venoplasty within AV graft, at venous anastomosis, fistula, and remainder of zone 1 (use once for zone 1 stenosis, <u>do not</u> use if G0392 already billed)	G0393	75978
Angioplasty within AV graft or fistula (at arterial anastomosis)	G0392	75962

The change is: Moved the instruction regarding which one can be billed when both are performed

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6. Code G0393 applies to all of zone 1. If the only stenosis treated with venoplasty is in the native cephalic or basilic vein, use G0393 along with 75978.

The change is: Changed basillic to basilic

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10. Arterial anastomotic angioplasty of a true documented arterial anastomotic stenosis should be coded G0392 and 75962 for Medicare effective January 1, 2007. If a venous stenosis in the same zone is treated, **do not** code for separate treatment of the venous stenosis in zone 1. Coding of an angioplasty in a native arterial stenosis is allowed and is not controversial. Codes 35475 and 75962 apply for this procedure. It must be well documented as to exact location, must be separate and distinct, be substantially away from the arterial anastomosis, and have documentation of severity of stenosis. It should not be coded separately

with codes 35475 and 75962 if called "juxta-anastomotic stenosis', as this is the anastomosis.

The change is: Changed the procedure that cannot be coded from arterial angioplasty to venoplasty and removed sentence stating use is payor-specific, since it is guided by CCI edits

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11. Code one angioplasty (G0392) if both arterial and venous anastomoses are treated with angioplasty. The graft is considered one vessel for coding purposes.

The change is: Changed G0393 to G0392 to accommodate new CCI edit April 1, 2009

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12. Only bill one "G" code per extremity. Code G0392 should be billed instead of code G0393 if both procedures are performed.

The change is: Reversed codes G0392 and G0393 to accommodate new CCI edit April 1, 2009

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13. If arterial anastomotic or juxta-anastomotic angioplasty is done, **do not** code for venoplasty in the shunt or outflow veins of the extremity.

The change is: Changed to the arterial angioplasty as the procedure that can be coded

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30. Per Correct Coding Solutions, LLC (the Medicare contractor responsible for NCCI edits):

    CMS will implement the edit reversing the order of the codes and not allowing use of NCCI-associated modifiers in NCCI version 15.1 scheduled for April 1, 2009. The implemented edit will have column one HCPCS code G0392 and column two HCPCS code G0393 so that the higher paying code is the column one code. The column one code is the code that is payable if both codes of this code pair are reported together.

    HCPCS codes G0392 and G0393 became active codes on January 1, 2007. Prior to that date, percutaneous transluminal balloon angioplasty of a hemodialysis access (e.g. arteriovenous fistula or graft) was reported with CPT codes 35476 (transluminal balloon angioplasty, percutaneous; venous) or 35475 (transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel). These CPT codes are non-specific with regard to anatomic site and created potential coverage and payment issues in the Ambulatory Surgical Center (ASC) site of service. CMS adopted HCPCS codes G0392 and G0393 to be used in lieu of CPT codes 35476 and 35475 to provide specificity with regard to anatomic site and coverage and payment for percutaneous transluminal angioplasty of a hemodialysis access in the ASC site of service. CMS did not intend to

introduce codes that would change the nature of the procedure or its coding.

Therefore, CMS will allow only one percutaneous transluminal balloon angioplasty code to be reported for the procedure performed on a hemodialysis access. Current coding conventions should be followed. The entire fistula or graft from the arterial anastomosis and the outflow vein up to, but not including, the subclavian vein is considered a single "vessel", and only one code may be reported for percutaneous transluminal balloon angioplasty of this vessel. If access to this "vessel" for the procedure is through an artery, HCPCS code G0392 should be reported. If access to this "vessel" for the procedure is through a vein, HCPCS code G0393 should be reported.

The change is: Added a new instruction with reference information.

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EXAMPLE(S):

1) Patient presents with a clotted left forearm AV dialysis shunt. The graft is accessed from both the arterial and venous sides (36145, 36145-59). Images are performed of the graft followed by imaging of the arm veins, central veins, and superior vena cava (75790). Stenoses of the venous anastomosis, basilic vein, and subclavian vein are identified. A mechanical thrombectomy with balloon extraction as well as administration of a thrombolytic agent is performed (36870) of the clotted graft. The two venous stenoses in the arm are angioplastied (G0393, 75978). Only one venoplasty is billed for the arm because the stenoses are in the same zone. A separate central venoplasty of the subclavian vein is billed with codes 35476 and 75978. The arterial anastomosis is also angioplastied due to stenosis (G0392, 75962, delete G0393, 75978 as venous angioplasty of the shunt is bundled into the arterial anastomotic angioplasty).
The change is: Changed the angioplasty codes billed from G0393 and 75978 to G0392 and 75962