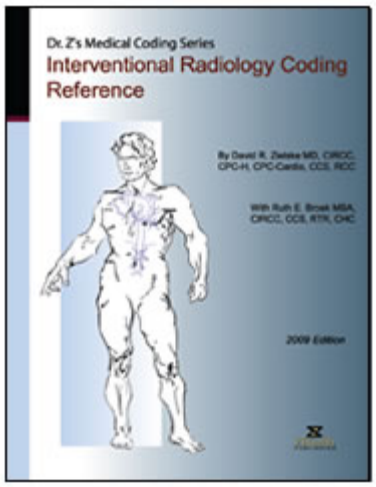

Dr Z's Medical Coding Series:
Interventional Radiology Coding Reference: 2009 Edition

2009 Book Errata

Page 33
Last paragraph
When performing clinical research studies, there are related services performed that are not part of the clinical study itself, but in support of it.
The change is: Added the word "part" to the sentence

Page 122
Instruction 12 should read:
12) Aortogram from high catheter position. Contralateral unilateral run-off from low aortic position. Ipsilateral run-off via the sheath (36200, 75625, 75716).
The revision is to correct a typographical error. Code 75626 should be 75625.

Page 153
Revise Coding Instruction 9 to:

9. A "midline" catheter placed in the arm and advanced with the tip in the subclavian vein is a central catheter (PICC) for coding purposes. Use code 36569 to describe this procedure. If the catheter can only be advanced with the tip in the axillary vein, (e.g., secondary to subclavian vein occlusion), then report code 36569 with reduced service modifier -52.

The revision is to indicate that when the catheter is only advanced to the axillary vein, less than a complete procedure has been performed, as the axillary vein is not a central vein. Modifier -52 must be appended to indicate the reduced service since there is no other code to describe this placement.

Revisions to Dr Z's Medical Coding Series:
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Page 153
Add under references:
American College of Radiology, Clinical Examples in Radiology, Fall 2008, pages 5-6

Page 165
Add as a new Number 16 under Coding Instructions and renumber existing instructions:
16. Use codes 37202-50 and 75896, 75896-59 to describe use of FlowMedica's "Benephit" catheter for infusion of Fenoldopam to prevent contrast-induced nephropathy. This targeted renal therapy involves placement of the split catheter into each renal artery and infusion of Fenoldopam for 60-180 minutes. This is a non-thrombolytic catheter-directed infusion into two separate organs, thus 37202 twice. Also report selective catheter placements with 36245-50.

New instruction on how to report a new therapeutic procedure.

Page 187
Revise Coding Instruction Number 9 to read:
9. **Do not** use code 37204 for endovenous ablation therapy of incompetent or varicose veins. Specifically, do not use code 37204 to describe catheter-directed gelfoam injection to occlude varicose veins.

Added other procedures code 37204 could not be used to report.

Page 190
CODES

Vasospasm treatment, initial vessel	61640	N/A	N/A
Vasospasm treatment, each additional vessel, same vascular family	☆61641	N/A	N/A
Vasospasm treatment, each additional vessel, separate vascular family	☆61642	N/A	N/A

The change is: Removed diamond symbol indicating these procedures are inpatient only. They are non-reportable by hospitals and non-covered for physicians.

Page 192
Add a new Number 10 under Coding Instructions and renumber current Number 10 to Number 11 and renumber the rest:
10. When G0392 is used, also report radiological S&I code 75962. When G0393 is used, also report radiological S&I code 75978.

Addition of a clarification that the set of two codes are always reported together.

Page 192
Add to end of instruction 11 (old instruction 10):
When both arterial and venous angioplasties are performed in zone 1, report only code G0392.
The change is: Added a sentence to clarify that G0392 is to be coded in the example

Page 195
Add under References:
American College of Radiology, Clinical Examples in Radiology, Fall 2008, page 10

Page 210
CODES

Vasospasm treatment, initial vessel	61640	N/A	N/A
Vasospasm treatment, each additional vessel, same vascular family	☆61641	N/A	N/A
Vasospasm treatment, each additional vessel, separate vascular family	☆61642	N/A	N/A

The change is: Removed diamond symbol indicating these procedures are inpatient only. They are non-reportable by hospitals and non-covered for physicians.

Page 222
CODES

Venoplasty within AV graft, at venous anastomosis, fistula, and remainder of zone 1 (use once for zone 1 stenosis, do not 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

Page 223
Add a new Number 1 under Coding Instructions and renumber existing Coding Instructions:
1. When G0392 is used, also report radiological S&I code 75962. When G0393 is used, also report radiological S&I code 75978.

Addition of a clarification that the set of two codes are always reported together.

Page 224
Under Coding Instructions (old Number 13 and will be new Number 14):
13. If arterial anastomotic or juxta-anastomotic angioplasty is done, do not code for venoplasty in the shunt or outflow veins of the extremity as G0392 includes other venoplasties in zone 1.

Added an explanation as why they can't be coded.

Page 224
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. (Changing to Number 7)

Page 224
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. (Changing to Number 11)

Page 224
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 (changing to Number 12)

Page 224
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 (changing to Number 13)

Page 224
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 (new Number 14)

Page 225

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.

Please note: Our interpretation is an angioplasty of the arterial anastomosis is G0392 and a venoplasty in the extremity veins related to dialysis graft is G0393, regardless of the access to the vessel (approach).
The change is: Added a new instruction with reference information. (changing to Number 31)

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Pages 225-226
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

Page 263-264
Under Coding Instructions:

2. Do use code 50395 for creation of a tract from the skin to the renal pelvis for subsequent endourological intervention. Do use code 74485 for balloon dilation of the tract from the skin to the renal pelvis unless performed at the same setting as nephrostolithotomy (50080 or 50081). Codes 50080 and 50081 include dilation of the tract at the same setting.

The revision is to clarify that 50395 and 74485 are reported separately for a staged procedure and that 74485 is included in 50080 and 50081.

Page 264
Add under Coding Instructions:

6. Use only code 74485 for dilation of tract from skin to kidney performed on established nephrostomy tube tract on different date of service than 50080 or 50081.

Revision to clarify that 74485 cannot be reported on the same date as 50080 and 50081.

Page 264
Add under references:
AMA eBookNews, March 11, 2009

Page 266
Revise Coding Instruction 4 to:

4. Codes 50080 and 50081 do not include creation of access to the kidney. Report code 50395 for tract creation when performed in conjunction with percutaneous nephrostolithotomy. Codes 50080 and 50081 include dilation of the tract at the same setting.

The revision is to clarify that 50395 cannot be reported with codes 50080 and 50081.

Revisions to Dr Z's Medical Coding Series:
Interventional Radiology Coding Reference 2009

Page 266
Add under references:
AMA eBookNews, March 11, 2009

Page 289
Revise Coding Instruction 1 to:

1. Only code one method of stone removal. Most radiologists utilize codes 47630 and 74327 instead of code 47554.

Code 47360 is revised to 47630.

Page 289
Revise Coding Instruction 4 to:

4. Use codes 47630 and 74327 once per session, even if multiple stones are removed from the biliary system using multiple techniques.

Code 47360 is revised to 47630.

Page 316
Revise Codes Table to:

PROCEDURE DESCRIPTION	PROCEDURE CODE	S&I CODE
Injection of peritoneal dialysis catheter	49400	74190 vs 76000
Wire clearance, manipulation, and/or tPA injection for an obstructed peritoneal dialysis catheter	49999	76496

Revised the last row in the table.

Page 316
Revise Coding Instruction 4 to:

4. Do code 49999 and 76496 for clearance of an obstruction (e.g., fibrin sheath) in or around a peritoneal dialysis catheter by use of a wire or tPA injection or for repositioning of a peritoneal dialysis catheter.

The revision is to indicate that procedures performed to remove an obstruction from, and to reposition, a catheter are reported with unlisted codes.

Page 316
Add to Reference section:
American College of Radiology, Clinical Examples in Radiology, Fall 2007, pages 1-2

Page 335
Revise Coding Instruction 14 to:

14. Code 38220-59 and 38221 when a core biopsy and a marrow aspiration are performed at different sites (different access) on the same date.

Revised the sentence for syntax reasons. Replaced the word "both" in front of "core biopsy" with "a". Added "a" before "marrow aspiration".

Revisions to Dr Z's Medical Coding Series:
Interventional Radiology Coding Reference 2009

Page 336
Add the following reference:
CMS, National Correct Coding Initiative Policy Manual for Medicare Services, Version 14.3, October 1, 2008, Chapter 9, page 9

Page 351
Add to Codes table:

Wire clearance, manipulation, and/or tPA injection into obstructed tunneled pleural catheter	32999	76496

Page 351
Add to Coding Instructions:

6. Do code 32999 and 76496 for clearance of an obstruction (e.g., fibrin sheath) in or adjacent to a chest tube by use of a wire or tPA injection or repositioning of a chest tube.

The revision is to address how to code for removing a fibrin sheath in an indwelling catheter.

Page 351
Add under References:
American College of Radiology, Clinical Examples in Radiology, Fall 2007, page 2

Page 358
Revise Example 4 as follows:
4) Patient with proximal femur tumor. This is treated with percutaneous RF ablation using CT guidance for needle placement (20982). Follow-up CT is unremarkable.
Changed "mass" to "tumor".

Page 358
Revise Example 6 as follows:
6) Patient with left renal tumor. This is treated percutaneously with RF ablation (50592) using ultrasound guidance (76940).
Changed "mass" to "tumor".

Page 364
Revise last row in the Codes table and add a new row:

Marker clip placement at time of breast biopsy	19295	
Marker clip placement for subsequent surgery or radiation therapy not at the time of a breast biopsy or with other breast procedure (not biopsy)	C9728 – Hospital 19499 – Physician	

Revisions to Dr Z's Medical Coding Series:
Interventional Radiology Coding Reference 2009

Page 364

Add under Coding Instructions:

7. Hospitals use HCPCS code C9728 to describe placement of a fiducial marker for subsequent radiation therapy or surgery. Code C9728 applies to placement of a fiducial marker anywhere in the body where a site-specific code does not exist. For example, if a fiducial marker is placed in the breast for a lesion only identified under MRI for subsequent surgery, hospitals should use code C9728 and physicians should use unlisted code 19499. Code 19295 describes placement of a clip at the same session as a breast biopsy, which wouldn't be described in this example.

Revision to provide instructions for coding placement of fiducial markers when not associated with a breast biopsy.

Page 366

Revise the next to the last row in the Codes table and add another row below it:

Marker clip placement at time of breast biopsy	19295	
Marker clip placement for subsequent surgery or radiation therapy not at the time of a breast biopsy or with other breast procedure (not biopsy)	C9728 – Hospital 19499 – Physician	

Page 367

Add under Coding Instructions:

11. Hospitals use HCPCS code C9728 to describe placement of a fiducial marker for subsequent radiation therapy or surgery. Code C9728 applies to placement of a fiducial marker anywhere in the body where a site-specific code does not exist. For example, if a fiducial marker is placed in the breast for a lesion only identified under MRI for subsequent surgery, hospitals should use code C9728 and physicians should use unlisted code 19499. Code 19295 describes placement of a clip at the same session as a breast biopsy, which wouldn't be described in this example.

Revision to provide instructions for coding placement of fiducial markers when not associated with a breast biopsy.

Page 372

Revise Coding Instruction 3 to read:

3. Report each additional cyst aspirated with code 19001. Report the guidance procedure only once per patient encounter.

The revision is to comply with the instruction given by CMS that guidance procedures are reported only once per patient encounter.

Revisions to Dr Z's Medical Coding Series:
Interventional Radiology Coding Reference 2009

Page 372
Revise Example to:
1) Woman presents with right breast pain. Ultrasound at the referring physician's clinic revealed two cysts, one at 3 o'clock and one at 7 o'clock. The right breast is prepped and draped. Under sterile ultrasound guidance a 20 gauge needle is placed into each separate lesion (19000, 19001, 76942) and fluid is aspirated until the cyst is no longer visible with ultrasound. Fluid is submitted for cytology.
Removed one instance of 76942 to comply with the instruction given by CMS that guidance procedures are reported only once per patient encounter.

Page 372
Add under References:
CMS, National Correct Coding Initiative Policy Manual for Medicare Services, Version 14.3, October 1, 2008, Chapter 9, page 9

Page 384
Revise Coding Instruction 9 to read:

9. Code 27093 is for hip arthrography **without** an anesthesiologist present. In the rare instance when hip arthrography is performed **with** an anesthesiologist providing anesthesia care, the radiologist would report 27095 and the anesthesiologist 01200.

The revision is to clarify that with anesthesia in the context of code 27095 means anesthesia administered by an anesthesiologist.

Page 385
Add under References:
American College of Radiology, Clinical Examples in Radiology, Fall 2007, page 7

Page 497
First sentence – delete repeated period