Coding Peripheral Angioplasties

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Like other interventional procedures, peripheral angioplasties involve complex combination coding. Surgical and radiological supervision and interpretation codes must be assigned for each procedure. In some instances multiples of both code types are assigned. This article discusses the various types of transluminal peripheral angioplasties and the appropriate code assignment for each.

The Procedures and Codes

Transluminal peripheral angioplasties are divided into two categories: open and percutaneous. Open peripheral and visceral transluminal angioplasties are coded to code range 35450-35460, and percutaneous transluminal peripheral angioplasties to 35470-35476. Open transluminal atherectomies are coded to 35480-35485, and percutaneous peripheral angioplasties to 35490-35495. Coding professionals should read the full code description to ensure the correct code assignment.

Percutaneous Transluminal Angioplasties

Percutaneous transluminal angioplasty is a procedure in which a narrowed arterial wall is widened by compressing the atheromatous plaque by successive balloon inflations. The procedure is performed from the inside (transluminal) and through a puncture in the skin (percutaneous). A catheter is usually inserted via the femoral artery, advanced to the aorta and further to the area of narrowing. The balloon is then inflated, and the arterial patency reestablished. The pressure of the balloon is measured in atmospheres. Multiple inflations may be required to correct the narrowing and improve blood flow.

The transluminal angioplasty CPT codes are specific to each artery. This is not a hierarchical system; each artery that is plastied is coded. For example, if the aorta is plastied, the code is 35452. If a renal artery is also treated, the code is 35450. If there are two or more areas of narrowing within an artery and each is angioplastied, the code is still assigned only once per artery.

If an unusually large number of areas must be plastied, the physician may assign modifier 22 to indicate that the procedure was more complex and time-consuming than usual. However, he or she should be prepared to submit documentation to support the use of this modifier. Modifier 22 is not approved for hospital use and should not be assigned for Hospital Outpatient Prospective Payment System reimbursement.

In addition to the CPT code for the interventional therapeutic procedure, a separate code for catheter placement must be assigned as well. These codes are selective in nature unless only the aorta is accessed. In selective vascular catheterization the catheter tip is manipulated out of the aorta, or the vessel originally punctured, and into another part of the arterial system. Thus, a typical therapeutic interventional radiology procedure would have at least three codes assigned to completely report the service:

- The catheter placement code
- The therapeutic code (such as transluminal angioplasty)
- The radiological supervision and interpretation code

Percutaneous Transluminal Atherectomy

A percutaneous transluminal atherectomy is performed much like a transluminal angioplasty, except that the mechanism for widening the lumen of the artery or vein is different. Instead of balloon inflations, the plaque is reamed out with tiny blades.

Percutaneous transluminal atherectomies have been termed "Roto-Rooter" procedures. Again, access to the site of the narrowing is via catheter, usually from the femoral artery, via the aorta and out into the affected artery.

As with transluminal angioplasties, the atherectomy codes are vessel-specific. Each vessel treated is reported by assigning a separate code.

If both a percutaneous transluminal angioplasty and a percutaneous transluminal atherectomy are performed on the same vessel, code only the atherectomy. This is considered a more comprehensive code and includes the angioplasty.

If two vessels are treated, one by angioplasty and one by atherectomy, two codes are assigned, though a modifier may be necessary. For example, a percutaneous transluminal angioplasty is performed on the right renal artery and a percutaneous transluminal atherectomy is performed on the left renal artery. The appropriate codes are 35471-RT and 35490-LT to show that these procedures were performed on different arteries. The RT and LT modifiers are used for those health plans that accept HCPCS level II anatomic modifiers, such as Medicare.

Modifiers would not be needed if the arteries were not paired. For example a percutaneous transluminal atherectomy on a renal artery (35490) and a transluminal angioplasty on an iliac artery (35473) would not necessarily have to be modified, although coding guidelines suggest that if a modifier can be used, it should be used.

As with percutaneous transluminal angioplasties, additional codes for the placement of the catheter and the radiological supervision and interpretation are needed when reporting atherectomies.

Families of Vessels

All interventional vascular procedures are based on the concept of families of vessels. A vascular family (or tree) is a group of arteries that is fed by a primary branch of the aorta or a primary branch of the vessel punctured. The branches of the vascular families are called orders of vessels. The aorta is the trunk of the tree.

Main branches directly off the aorta are known as first-order vessels. Branches of first-order vessels are second-order vessels. Branches of second-order vessels are third-order vessels. Because any vessels beyond third order are too small to be engaged with catheters, no more refined vessel divisions are made for coding purposes. Coding is based on the vascular family catheterized and the extent catheterized; that is, how far out on the limbs of the vascular tree the needle goes.

Stent Placement

A stent is a tiny spring-like device that provides support for a tubular structure and improves its patency. Stents may be bare metal or impregnated with drugs to prevent in-stent restenosis (drug-eluting stents). Although drug-eluting stents have been used for some time in coronary arteries, they are still in clinical trials for peripheral arteries. A third type of stent, antibody-coated, is being used in Europe and Canada but has not been approved by the FDA for use in the United States yet.

CPT code 37205 describes the percutaneous placement of an intravascular noncoronary stent in the initial vessel, and 37206, an add-on code, describes each additional stent placement in additional vessels. This code is not vessel-specific and is used for all noncoronary stent placements. Multiple stents may be placed within a vessel, adjacent to each other, overlapping each other, or at some distance apart. Even if multiple stents are placed within a single artery, CPT code 37205 is the only code reported. Code 37206 is applied only if stents are placed in other, additional arteries.

If a transluminal angioplasty or atherectomy is performed during the same operative session as the stent placement, as is frequently the case, that procedure is coded as well. Coding conventions for both transluminal angioplasty and transluminal atherectomy apply, with only the latter being coded if both are performed. In addition, radiological supervision and interpretation codes and codes for catheter placement are also assigned.

NCCI Edits

The Centers for Medicare and Medicaid Services'
National Correct Coding Initiative (NCCI) aims to promote national correct coding methods and control improper coding leading to inappropriate payment in part B claims. The four general NCCI principles most relevant for percutaneous vascular procedures are:

- Standards of medical care--it is assumed that if one makes an incision, he or she also closes it as part of the procedure.
- Most extensive procedure--placement of a catheter in a third-order artery is more extensive than placement in a first-order artery.
- Sequential procedure--all the selective catheterizations performed along the way to the most extensive procedure are not coded.
- Supplemental codes--code 37206, intravascular stent placement, each additional vessel, is an add-on code and cannot stand alone.

The NCCI is updated quarterly. Hospitals always use the prior quarter's edits; physicians, the current quarter's edits. Both the cardiovascular system edits and the radiology edits should be reviewed to ensure that no NCCI principles are being violated when reporting these procedures.

Radiological Supervision and Interpretation Codes

Radiological supervision and interpretation codes fall within the 70000-79999 range. They are typically assigned from the chargemaster by radiology technicians or support staff in the radiology department at the time of the procedure. Coding professionals should be aware of the relationships between the interventional and radiological codes, however, and may assist in ensuring that the appropriate code is submitted for these procedures.

Just as each artery angioplastied should be coded, radiological supervision and interpretation CPT codes should be assigned for each procedure for outpatient and physician service reporting. Code 75962 is for the first peripheral artery plastied, and 75964 for each additional peripheral artery. Code 75966 is for the first renal or visceral artery, and 75968 is for each additional visceral or renal artery.

The radiological supervision and interpretation codes for percutaneous transluminal atherectomies lie in the 75992-75996 range. There are separate codes for peripheral arteries, renal arteries, and visceral arteries. Code 75996 is assigned only when a separate, additional artery is atherectomized, not when multiple atherectomies are performed in a single artery.

The radiological supervision and interpretation code for stent placement is 75960, assigned for each artery stented, but only once per artery.

Susan Hull *was a practice manager at AHIMA from 2002-2006. AHIMA is sad to report her death on April 8, 2006. She will be missed.*

Article citation:
Hull, Susan. "Coding Peripheral Angioplasties" *Journal of AHIMA* 77, no.5 (May 2006): 72-74.