Coding  Lower  extremity revascularizations:  Tibial arteries

January 18, 2018

Question:
For an angioplasty or stenting in the tibia vessels how is the tibio-peroneal trunk coded?

Answer:
The tibio-peroneal trunk is considered part of the peroneal and posterior tibial vessel. It is not included in the anterior tibial. Therefore if angioplasty and stenting was performed in the tibio-peroneal trunk and the anterior tibial artery, codes 37230 and the add on code +37324.

*This response is based on the best information available as of 01/18/18.

Defining  Non-Compounded Sclerotherapy

January 4, 2018

Question:
I’m not sure I understand the new vein surgery codes in the 2018 CPT manual. Can you explain what “non-compounded” means?
Answer:
The new 2018 coded, 36465, 36466 describe injection(s) of a non-compounded foam sclerosant into an extremity truncal vein (eg, great saphenous vein, accessory saphenous using ultrasound-guided compression of the junction of the central vein (saphenofemoral junction or saphenopopliteal junction). The sclerosant comes ready to use, it does not need to be compounded (prepared or mixed) by the provider. Note that these new codes also include ultrasound-guided compression. Code 76942 for ultrasound guidance would not be separately reported.

The existing sclerotherapy codes, for example, 36470, sclerotherapy injection of sclerosant, single incompetent vein (other than telangiectasia), describe a sclerosant solution that is mixed (compounded ) by the provider prior to injection.

The codes for non-compounded (36465-36466) and compounded (36470-36471) sclerotherapy are shown below.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Global Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>36465</td>
<td>Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein) <strong>New in 2018</strong></td>
<td>10</td>
</tr>
<tr>
<td>36466</td>
<td>multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg <strong>New in 2018</strong></td>
<td>10</td>
</tr>
<tr>
<td>36470</td>
<td>Injection of sclerosing solution; single vein</td>
<td>10</td>
</tr>
</tbody>
</table>
I performed a right common carotid artery catheterization with extracranial common carotid and intracranial imaging and left internal carotid catheterization with carotid circulation imaging. Can I report this as bilateral, 36224 and 36223-50?

Answer:
The bilateral modifier is only used for the exact same procedure/code performed bilaterally.

In your scenario the codes will be:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36224</td>
<td>for the left internal carotid catheterization with intracranial imaging, and</td>
</tr>
<tr>
<td>36223-59</td>
<td>for the right common carotid artery catheterization with extracranial and</td>
</tr>
<tr>
<td></td>
<td>intracranial imaging</td>
</tr>
</tbody>
</table>

*This response is based on the best information available as of 12/14/17.
Cervicocerebral Imaging — What’s Not Included

November 30, 2017

Question:
What’s not included in the diagnostic cervicocerebral imaging codes and can be reported separately?

Answer:
The diagnostic cervicocerebral imaging codes do not include:

- Interventional procedures such as angioplasty or embolization
- Endovascular stent placement
- Ultrasound guidance for vascular access, e.g., 76937 with 36221-36228
- Selective arterial catheterization outside the carotid and vertebral arteries and branches
- 3-D rendering, e.g., 76376 or 76377
- Moderate sedation (99151-99157).

*This response is based on the best information available as of 11/30/17.
Cervicocerebral Imaging – What’s Included

November 16, 2017

Question:
What’s included in the diagnostic cervicocerebral imaging codes and not separately reported?

Answer:
The diagnostic cervicocerebral imaging codes include:

- Accessing the vessel
- Non-selective aortic and selective innominate, carotid and vertebral catheterization
- Contrast injection(s) of aortic arch, carotid and vertebral systems, including arterial, capillary, and venous phase, when performed
- All fluoroscopy
- All radiological supervision and interpretation
- Closure of the arteriotomy by pressure or application of an arterial closure device

*This response is based on the best information available as of 11/16/17.
Thrombolysis and Catheterization

October 19, 2017

Question:
If a thrombolysis infusion catheter is placed, can the catheterization (for example 36247) be billed in addition to the thrombolysis (37211)?

Answer:
Yes, the catheterization, (36245-36247) may be separately reported in addition to the thrombolysis code (37211). Remember, if a diagnostic angiogram is also performed, this may also be separately reported.

*This response is based on the best information available as of 10/19/17.

Thrombectomy in the Dialysis Circuit

October 5, 2017

Question:
If thrombectomy is performed once in the peripheral segment and once in the central segment of the dialysis circuit, can code 36904 be reported twice?

Answer:
Code 36904 is reported once, no matter how many times thrombectomy is performed in the peripheral and/or central segment.

*This response is based on the best information available as of 10/05/17.

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**Coding Debridement for an Ulcer**

September 21, 2017

**Question:**
I debrided and ulcer. How do I know if I use 97965 or 11042?

**Answer:**
Code 97597 is described by CPT as a debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less. By definition it is exclusively for selective debridement of the skin, epidermis and dermis.

In contrast, code 11042, is for a deeper selective debridement, one that includes the dermis, epidermis and subcutaneous tissue. The code description states *Debridement, subcutaneous tissue (includes epidermis and dermis, if*
performed); first 20 sq cm or less.

For any debridement make sure to document the depth of the tissue debrided, the location of the debridement and the size of the debridement. Other selective debridement codes (11043 and 11044) are also coded by the depth of tissue removed; muscle and/or fascia for 11043 and bone for 11044.

*This response is based on the best information available as of 09/21/17.

Assistant Surgeon Payments

September 7, 2017

**Question:**
We are seeing payors ask for payment back when we use Modifier 80 for assistant surgeon. Is there a reason why they would take the payment back?

**Answer:**
We are seeing payors including Medicare and Medicaid ask for payment recovery when the documentation does not explain what role the assistant played in the surgery. It is not enough to state that the procedure was complex. Specifics of what the assistant did, assisted with the resection and anastomosis for example, must be documented to support billing for an assistant surgeon.

*This response is based on the best information available as of 09/07/17.*
How do I know if co surgeon will be paid? What about assistant surgeon?

August 24, 2017

**Question:**
How do I find out if an assistant surgeon or co-surgeon is paid on certain procedures that I perform?

**Answer:**
This information is published by Medicare on the Medicare website.

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html)

You can also google “Physician Fee Schedule Look up” to access the site. Once there, you can enter a single or up to four CPT codes. Follow the prompts and indicate your search is for “payment policy indicators” (see the search choices below, Table 2). The search will show the codes and several policies, including numbers (see table 3), 0, 1, 2, 9 that indicate the payment status of the code. Table 4, tells you what those codes mean; paid, paid with documentation or not paid.

**Table 1**
Table 2
Table 3
Table 4 Policy indicators

<table>
<thead>
<tr>
<th>Co-Surgeon (62)</th>
<th>Assistant Surgeon (80-82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Co-surgeon not permitted</td>
<td>0 = Paid with documentation</td>
</tr>
<tr>
<td>1 = Paid with documentation</td>
<td>1 = Not paid</td>
</tr>
<tr>
<td>2 = Paid with two specialties</td>
<td>2 = Paid</td>
</tr>
<tr>
<td>9 = Concept does not apply</td>
<td>9 = Concept does not apply</td>
</tr>
</tbody>
</table>

*This response is based on the best information available as of 08/24/17.*