FEVAR? What Is It?

Question:

My doctor is doing a FEVAR procedure. What exactly is a FEVAR?

Answer:

FEVAR, or fenestrated endovascular aortic aneurysm repair, is an endovascular approach to the repair of an abdominal aneurysm that involves the upper abdominal or visceral aorta. This mid portion of the aorta contains the celiac, superior mesenteric and renal arteries. FEVAR codes, 34841-34848, report the placement of an endograft into this section of the aorta. The endograft has fenestrations (or openings) to accommodate the visceral arteries. The codes are selected based on the number of fenestrations (1, 2, 3 or 4 openings) and the configuration of the device (the extent of the aorta involved). Please refer to your CPT manual for a detailed description of the eight new codes.

Providing Exposure for a Spine Procedure? What’s the Correct Code?

Question:

I provide the retroperitoneal exposure for a neurosurgeon colleague for an anterior spine procedure. My partner went to the SVS coding course and tells me this is co-surgery. I have been billing 49010 for the exploratory laparotomy, retroperitoneal, since that is what I am doing and I have been
getting paid without any problem. What is the correct coding for this situation?

Answer:

Your partner is correct and confirms the value of attending a coding course! The anterior spine procedure performed by the neurosurgeon, typically an anterior lumbar interbody fusion (22558), is valued for the approach, the procedure, and the closure. Therefore, you are doing a distinct part of that CPT code and are therefore acting as a co-surgeon. Reporting 49010 is essentially double billing the approach. To code this correctly, both you and the neurosurgeon should report 22558-62 for this work.

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**Thrombolytic Infusion Coding: Can I Bill for Each Day?**

**Question:**

The thrombolytic infusion code, 37211, has a 0 day global period. Does that mean if I have an infusion that continues into a second day I should report 37211 again on day 2?

**Answer:**

The thrombolytic infusion code, 37211, Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological S & I, initial treatment day, is for the first day of treatment only. If the infusion continues on the next day, report 37213, Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological S & I, continued treatment on subsequent day
during course of therapy. CPT code 37213 includes contrast injection into the catheter and associated image interpretation, as well as any catheter repositioning or exchange.

Debridement of a Foot Ulcer During the Global Period of a Bypass. Billable or Not?

Question:

I did a right fem-pop bypass on a patient who had a pre-existing ulcer on the right foot. When he came in for his post-op visit, I debrided the ulcer. Is the debridement considered part of the global period and not billable?

Answer:

The patient’s ulcer is not a complication of the bypass that you performed, but rather a result of the patient’s underlying peripheral vascular disease. Therefore, it is unrelated to the surgery that you performed (it was not caused by the surgery) and may be reported during the global period of the bypass with a 79 modifier.

Stab Phlebectomy- Less Than
10 Stabs. What To Do??

**Question:**

I did a stab phlebectomy of 8 stabs in the right leg. I see the code 37765 is for 10-12 stabs. Does that mean I can’t use that code for 8 stabs?

**Answer:**

You are correct that the codes for stab phlebectomy are for the number of stabs per extremity; 37765 for 10-20 and 37766 for more than 20. If you perform less than 10, you can still bill the procedure, but you must bill it as an unlisted code, 37799. Set your fee at approximately 75% of your fee for 37765.

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**Carotid Endarterectomy Performed Bilaterally On Different Dates**

**Question:**

We are having a debate in our office. The surgeon performed a right carotid endarterectomy on a patient and then brought the patient back to do the left carotid 2 weeks later. I know a modifier is needed on the second procedure since endarterectomy has a 90 day global. Would a 58 modifier be the appropriate modifier?

**Answer:**

Although it was known in advance that the left carotid would
be done in a “staged” approach following the right, the more appropriate modifier is a 79, unrelated procedure. The right carotid surgery is performed at a different operative site and is unrelated to the surgery performed on the left.

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**Billing Carotid Stent Without Embolic Protection**

**Question:**

During angioplasty and stent placement of the carotid artery, I was unable to deploy the embolic protection device even though it was my intent to do so. Can I bill 37215, carotid stent with embolic protection with a 52 modifier? Medicare will not pay for the carotid stent code without embolic protection.

**Answer:**

You are correct. Medicare national coverage policy does not cover carotid stent without embolic protection, CPT code 37216. However, if you are unable to deploy the protection device, regardless of the reason, you must report 37216. 37215 with a 52 modifier would not be appropriate.

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**Cerebral Angiograms and**
Modifier 26

Question:

The prior cerebral angiogram codes in the 70000 series of CPT codes required a 26 modifier. Do we append a 26 modifier to the new codes?

Answer:

The new cervicocerebral angiogram codes are now surgical codes in the 30000 series of CPT codes, not radiology codes. Therefore, they do not require a 26 modifier to indicate the physician is performing the professional component only. Like other surgical codes, these new codes reflect only the physician’s work.

Help! Denial of Stent Codes for Treating AV Graft Stenosis.

Question:

We recently had several denials for placing a stent in an AV graft for graft stenosis. We billed 37205 and the radiology code. Both were denied. Can you help?

Answer:

The stent codes (for stents other than lower extremity, cervical carotid, extracranial vertebral or intrathoracic, intracranial, or coronary) were totally revised effective in January 1, 2014. 37205 and 75960 the associated radiological
supervision & interpretation (S & I) codes were deleted and replaced with the following code:

| 37238 | Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic, intracranial, or coronary), open or percutaneous, including all supervision and interpretation and including all angioplasty within the same vessel, when performed; initial vein. |

This is now the correct code to using for stenting an occluded AV graft. As stated in the code, it now includes the radiological S & I.

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**Denials for Cervicocerebral Codes!**

**Question:**

Several payors are denying certain cervicocerebral codes when appropriately billed together. For example, an internal carotid angiogram (36224) and a vertebral angiogram (36225). I know these are correctly reported together, so what do I do with these denials?

**Answer:**

We see denials for this accurate code combination from many payors. Appeal this denial, attach a copy of the CPT page that specifically states these codes may be reported together. Additionally, include documentation showing there is no Medicare CCI edit (for example, from the Medicare website or
your coding software). This may take perseverance on your part, but if you are reporting these code combinations correctly, continue to work with the payor(s) to have these procedures paid!