Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 35476 Accuracy Hinges on AV Shunt Segment Definitions

Pinpoint arterial code opportunities by understanding the exception to the venous rule.

Ignoring guidelines is a surefire way to get arteriovenous shunt intervention coding all wrong. To keep your claims pristine, take care to apply these crucial CPT® definitions and rules.

For review: To learn more about diagnostic shunt studies, see Radiology Coding Alert, vol. 14, no. 4, "Guidelines in Focus: 36147 Features Official Includes/Excludes Rules in 2012."

Intervention Comprehension Starts With Anatomy

To master proper coding for arteriovenous (AV) shunt interventions, you have to know that "the

AV shunt is artificially divided into two vessel segments," according to CPT® guidelines. This is important because you calculate the number of interventions based on the number of segments involved rather than the number of lesions.

Segment 1: The peripheral segment extends from the peri-arterial (near the artery) anastomosis through the axillary vein. If the shunt has a cephalic venous outflow CPT® includes the entire cephalic vein in the first segment.

In other words, segment 1 includes:

- The shunt itself, whether a fistula or graft
- The opening (anastomosis) of the shunt into the artery
- The venous system starting with the vein connected to the shunt and going through to the axillary vein in the upper chest/shoulder region. (Humans have two axillary veins, one on each side.)

Alternatively, if the shunt involves a connection between an artery and the cephalic vein (creating cephalic venous outflow), then the entire cephalic vein is also part of segment 1. The cephalic vein runs from the lower arm up through to the upper chest/shoulder region where it joins with the axillary vein.

Segment 2: The second segment includes those veins "central to the axillary and cephalic veins, including the subclavian and innominate veins through the vena cava," CPT® guidelines state.

If the term "central to" doesn't offer you a clear picture of segment 2, imagine the vessels listed in the definition.

To start, picture the cephalic joining the axillary vein in the shoulder region, moving their combined blood flow into a single vessel, which becomes the subclavian vein at the first rib. The jugulars from the neck join the subclavian, which becomes the innominate (brachiocephalic) vein. The innominate is a short segment that flows into the superior vena cava, which runs into the heart.

If you follow the segment 2 vessels through the body, you see how they connect and combine until they reach the vena cava at the center of the body.

Count Segments for Venous Services

Now that you have a grasp on the anatomy, apply it to your coding.

First you need to understand how to count the interventions. CPT® guidelines instruct that "Interventions performed in a

single segment, regardless of the number of lesions treated, are coded as a single intervention." For example, if there are three lesions in segment 1, you should report treatment of all three lesions as a single intervention. As an alternative example, if the patient has one lesion in segment 1 and one lesion in segment 2, you should report a separate intervention code for each segment.

Next you need to know which codes to apply to interventions in the segments. Under CPT® rules, the AV shunt itself is considered to be venous (as opposed to arterial). As a result, most AV shunt interventions you'll see are "venous-venous," said **Sean P. Roddy, MD,** of the CPT® Advisory Committee and Society for Vascular Surgery, in his CPT® and RBRVS 2012 Annual Symposium presentation.

Angioplasty example: You should code venous-venous angioplasty of the AV shunt using the following codes:

- 35476, Transluminal balloon angioplasty, percutaneous; venous
- 75978, Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation.

Remember to report only one intervention per segment. According to CPT® guidelines, that means reporting 35476 and 75978 only once per segment, even if the physician uses multiple balloon catheters to open multiple lesions or inflates a balloon multiple times.

Also don't forget to apply the official definitions of "segment" here. Recall that Segment 2 includes multiple veins, such as the subclavian, innominate, and vena cava. If the physician performs angioplasty in each of those central veins, you still should report only one intervention per "segment," Roddy noted.

Stent example: Suppose the radiologist places two stents in segment 1 and two stents in segment 2. Because the rule is to code one intervention per segment, you should assign codes based on the number of segments treated rather than the number of stents placed.

For the first segment intervention, you should report:

- 37205, Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel
- 75960, Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel

You should report the second segment intervention using:

- +37206, Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)
- 75960.

Watch for the Artery Exception

In one very specific circumstance CPT® instructs you to report an arterial intervention in relation to the AV shunt.

Stenosis (narrowing) at the graft's arterial anastomosis often crosses into the artery itself. This area of the artery near the anastomosis may be documented as the peri-anastomotic or juxta-anastomotic region. If the physician uses angioplasty to treat a single lesion that crosses from the artery into the vein or graft, you should include the entire service in the following codes:

35475, Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel

75962, Transluminal balloon angioplasty, peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation.

Coding tip: When you report codes 35475 and 75962 for angioplasty of the peri-anastomotic region (artery and shunt), these codes cover all angioplasties performed in segment 1, as well. So for these particular arterial cases, you should not report venous angioplasty codes separately for segment 1 services.

Watch out: You should never report the venous/venous AV angioplasty code (35476) for removing an arterial plug, said Roddy. The arterial code (35475) also would not be appropriate. For this service, often documented as declot or thrombectomy, you should report 36870 (Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft [includes mechanical thrombus extraction and intra-graft thrombolysis]). The physician may use a balloon catheter for the service, but 36870 is still the appropriate choice.