Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Check FEVAR, Stent and Embolization Codes to Reflect the Latest Changes

Expanded 37241-37244 guidelines aim to help you capture catheterization pay.

The time has arrived for another roundup of corrections and revisions to cardiology-related codes in CPT® 2014. CPT® introduced these changes in March with an effective date of Feb. 10, 2014.

Factor In These 2 FEVAR Instruction Changes

The first set of changes affects instructions related to fenestrated endovascular repair (FEVAR) codes:

- 34841-34844, Endovascular repair of visceral aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed
- 34845-34848 Endovascular repair of visceral aorta and infrarenal abdominal aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed ...

First, take a close look at the "do not report 34841-34844 in conjunction with" code list that accompanies those codes. Be sure your coding resource has deleted from the list direct repair codes 35081 (Direct repair of aneurysm, pseudoaneurysm, or excision [partial or total] and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta) and 35102 (... for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels [common, hypogastric, external]).

The corrected instruction reads, "Do not report 34841-34844 in conjunction with 34800, 34802, 34803, 34804, 34805, 34845-34848, 35452, 35472, 75952."

Next, be sure you revise the instruction related to when you may use 34845-34848 in conjunction with 37220-37223 (Revascularization, endovascular, open or percutaneous, iliac artery ...).

Initially the instruction said to report the FEVAR codes (**34845-34848**) with the revascularization codes (**37220-37223**) only when FEVAR codes "**34845-34848** are performed outside the target treatment zone of the endoprosthesis" (bold added). The problem with that instruction is that the endoprosthesis is part of the FEVAR service, so you wouldn't perform FEVAR outside of the target FEVAR area.

The corrected instruction makes more sense, telling you to report the revascularization codes only when the revascularization services "37220-37223 are performed outside the target treatment zone of the endoprosthesis" (bold added).

Emphasize 37220-37235 Connection to Occlusive Disease

Intravascular stent codes 37236-+37239 have revised code descriptors and guidelines to bring them closer in line with the rule that lower extremity revascularization codes "37220-37235 are to be used to describe lower extremity endovascular revascularization services **performed for occlusive disease**" (bold added).

For instance, note how the reference to the lower extremity artery services in 37236-+37237 now reference occlusive disease (in bold):

- 37236-+37237, Transcatheter placement of an intravascular stent(s) (except lower extremity artery[s] for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed ...artery

You won't find a similar change in 37238-+37239 because those codes are for vein services rather than artery services:

- 37238-+37239, Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed ... vein

But the vein codes get pulled into a small guideline change, where CPT® again adds the reference to occlusive disease (in bold): "Codes 37236-37239 are used to report endovascular revascularization for vessels other than lower extremity **artery(s) for occlusive disease** (i.e., 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235) ..."

You'll see the same added phrase in the note following +37237: "For stent placement(s) in iliac, femoral, popliteal, or tibial/peroneal artery(s) for occlusive disease, see 37221, 37223, 37226, 37227, 37230, 37231, 37234, 37235."

Stent services and the embolization services described below are fairly common, notes **Christina Neighbors, MA, CPC, CCC,** Coding Quality Auditor for Conifer Health Solutions, Coding Quality & Education Department. So it's important to watch for any changes CPT® announces.

Don't Forget Cath Codes With 37241-37244

Finally, the corrections document spells out that you may report catheter placement and diagnostic angiography in addition to 37241-37244 (Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention ...).

The clarification does not change the rule, but the new wording makes the separately reportable services harder to miss. The new text is marked in bold in this updated instruction:

"The embolization codes include all associated radiological supervision and interpretation, intra-procedural guidance and road mapping, and imaging necessary to document completion of the procedure. **They do not include diagnostic angiography and all necessary catheter placement(s).** Code(s) for catheter placement(s) may be separately reportable using selective catheter placement code(s), if used consistent with guidelines. Code(s) for diagnostic angiography **may also be separately reportable, when performed according to guidelines for diagnostic angiography during endovascular procedures**, using the appropriate diagnostic angiography codes. Report these services with an appropriate modifier (e.g., modifier 59). Please see the guidelines on the reporting of diagnostic angiography preceding 75600 in the Vascular Procedures, Aorta and Arteries section."

Resource: The complete lists of revisions are available on the AMA's Errata and Technical Corrections page at www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/errata.page.