Part B Insider (Multispecialty) Coding Alert

Say Goodbye To Unlisted Codes For Patency Check, Radiofrequency Ablation

If you've been billing for a central venous access device assessment, known as a central line patency check, your troubles may be over.

Until now, you've had to bill for this procedure using an unlisted code plus a fluoroscopy code, says Cheryl Schad, with NJ-based **Schad Medical Management**. But now CPT 2006 will add a new code for this procedure (**CPT 36598**). "We might actually see some reimbursement for this procedure," exults Schad.

You'll use 36598 when your physician injects contrast to see if there's a problem with a venous access device (such as fibrin around the ends) or a change in position, says Jackie Miller, with Coding Strategies in Dallas, GA. The radiologist checks to see if the contrast is able to pass through.

More good news: Right now, you can only bill for mechanical thrombectomy if the physician performs it in a coronary vessel or arteriovenous fistula. But starting in January, you'll be able to bill for mechanical thrombectomy in peripheral vessels as well, says Miller.

New codes cover primary mechanical thrombectomy for noncoronary, arterial or arterial bypass graft for the initial vessel (37184) and each additional vessel (37185). Another new code covers secondary thrombectomy (37186). And a third covers percutaneous mechanical transluminal thrombectomy, including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance (37187) and a repeat treatment on a subsequent day (37188).

Lastly, new code 50592 covers radiofrequency ablation of one or more renal tumors. This is a very welcome change because previously you had to use an unlisted code, says Schad.