APS Update

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Mechanical Thrombectomy

In 2006, three new CPT codes were added to report mechanical thrombectomy. They are 37184 (Primary percutaneous transluminal mechanical thrombectomy, non-coronary, arterial or arterial bypass graft, including fluoroscopy guidance and intraprocedural pharmacological thrombolytic injection(s): initial vessel), 37184 (2nd and all subsequent vessel(s) within the same vascular family) and 37186 (Secondary percutaneous thrombectomy (eg, non-primary mechanical, snare basket, suction technique), non -coronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy). The distinction between "primary" and "secondary" thrombectomy is based on the intent. A thrombectomy is considered primary if the need for the other services was not known prior to mechanical thrombectomy. Other therapeutic procedures may be needed after a primary thrombectomy, such as angioplasty or stenting. Secondary thrombectomy is sometimes referred to as "rescue" mechanical thrombectomy and can also be performed in conjunction with another percutaneous intervention.

A common error is the reporting of code 36870 (Thrombectomy, percutaneous, arteriovenous fistula, autogenous or non-autogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis) for mechanical thrombectomy when this code should **only** be reported for mechanical thrombectomy in an AV graft. Incorrect reporting also affects revenue: per Ohio Medicare, code 36870 reimburses $1,940.31, whereas 37184 is reimbursed at $2,637.93. Fluoroscopic guidance is included and should not be reported separately. All other catheter placement, diagnostic studies and other percutaneous intervention is coded in addition to codes 37184, 37185 and 37186.

Hope on the Horizon for Office Procedures

On May 10, legislation was introduced into the Senate to put a two year hold on the reduction in Medicare technical component payment rates for office based imaging procedures included in the Deficit Reduction Act of 2005. The sponsors indicated in their submission that the reductions had been put into the 2005 legislation late in the process and that the impact had not truly been understood at that time. The Senate bill matches legislation that had been introduced in the House earlier in the year.

Important in the hopes for this bill is the fact that neither the Centers for Medicare & Medicaid Services, nor the Medicare Payment Advisory Commission asked for the reductions that were enacted. In addition, both parties indicated that they had not prepared any review on the effect of the reductions on access to care prior to their enactment. Part of the current legislation is a request that the General Accounting Office prepare an analysis of that impact.

The bill is named the Access to Medicare Imaging Act and should see action during this year.

Coding Tips For Non-Vascular Procedures

Vascular procedures are a large part of an interventionalist's typical day, but there are also many other procedures that are performed to diagnose and treat disease and trauma. Some of the common non-vascular procedures for example would include: drainages (obstructions of the urinary, biliary systems, remove abdominal fluid, etc.), biopsies (needle, catheters), artificial nutrition (feeding tubes), aspirations and destruction of abnormal tissue (radiofrequency). Here are some guidelines and tips when coding for these types of procedures.

* Code the appropriate CPT code for the procedure performed
* Code all appropriate Surgical and RS&I procedures
* Code appropriate imaging guidance. For example, 77002 (fluoroscopy), 77012 (CT) or 76942 (ultrasound).
* Report code 75989 for radiological supervision and interpretation of drainage procedures with placement of a catheter. Do not add 77002, 77012, 77021 or 76942 unless two separate procedures are performed, such as drainage of abdominal fluid and a needle biopsy of the kidney.
* Per CPT and the National Correct Coding Initiative (NCCI), many procedure codes already include fluoroscopy in the main procedure. In that case, fluoroscopy (77002, 77003) would not be separately reported.
* Spot films to check placement of central lines should not be reported with fluoroscopy code 77001. This film interpretation should be coded as an x-ray exam of the pertinent body area.
* For Medicare patients, bundling edits need to be considered. Many procedures are considered component elements to higher complex interventions. These are detailed in NCCI.
* If catheters or tubes are placed bilaterally, remember to add modifier -50 or RT and LT.
* Because it is common to have two physicians working together to accomplish a procedure, each physician's note must clearly indicate that he/she performed the procedure being billed.

Delay in Implementation of the New 1500 Form

Due to a printing error at the Government Printing Office the 12/90 version of the HCFA 1500 form will continue to be used at least through May, 2007. The 08/05 version of the form, which had been scheduled to go into effect on April 1, 2007 did not match the format of the form printed by the GPO and therefore could not be scanned. The importance is that the GPO provided the incorrect negative and forms to numerous vendors and providers for implementation.

Apparently, in the process of preparing the negative, the top margin was reduced and the resulting form had the word "Carrier" too close to the red arrow in the top right hand corner. To determine if you have an incorrect version of the form just look at that top corner. There should be a ¼ inch margin at the top. If the arrow appears to be very close to the printing, you have an incorrect form.

The delay in the use of the new form is not the same as the delay in the use of the NPI. The new version of the form has a position for the NPI but there is no federal regulation requiring the use of the NPI on the form. Medicare itself has said that the NPI must be there. Other states and payers have followed suit.

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