
CAROTID PROCEDURES CODING AND BILLING: IV

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CAROTID PROCEDURES

- ◆ In order for your billing department to properly code a peripheral procedure the PHYSICIAN must document the following:
- ◆ The approach (entry point of catheter)
- ◆ Each vessel that was selectively catheterized

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- ◆ The final destination of the catheter
- ◆ A separate description of the procedures performed in each system
- ◆ All vessels that were imaged

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- ◆ The coding system is designed to give physicians credit for the degree of difficulty to get from the puncture site to the final destination. The coding changes for some vessels depending on the direction of approach

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- ◆ Each major branch arising from the aorta is considered a primary branch or a first order vessel. Branches arising off of the first order vessels are 2nd order vessels. Branches arising off the 2nd vessels are 3rd order vessels
- ◆ The primary branch and all the secondary and tertiary vessels make up a vascular family

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- ◆ Only the highest order catheter placement in each vascular family can be billed
- ◆ Work in each vascular family should be documented separately in the procedure note

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- ◆ Selective catheterization is when the catheter is guided into a system other than the aorta or the vessel punctured
- ◆ You can not bill for a non-selective catheterization and a selective catheterization from the same access

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◆ The Great Vessels are the three vascular families off of the Aortic Arch

- The Innominate;
- The Lt Common Carotid;
- The Lt Subclavian

Selective catheter placements are coded in each that are engaged

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Angiograms

- ◆ 36216 Rt Common Carotid
- ◆ 36218 Rt Subclavian
- ◆ 36215-59 Lt Common Carotid
- ◆ 36215-59-76 Lt Subclavian
- ◆ These codes are for the catheter placement and injection of dye

AMA/CPT

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Radiological Supervision & Interpretation

- ◆ 75650-26 Arch w/vessel origin
- ◆ 75680-26 Carotid Cervical views
- ◆ 75671-26* Carotid Cerebral views
- ◆ 75716-26 Bilateral Subclavians
- ◆ 75685-26* Vertebral(s)

*When performed

AMA/CPT

CAROTID PROCEDURES

- ◆ Medicare does have an NCD regarding Carotid Stenting

www.cms.hhs.gov/transmittals/downloads/R87NCD.pdf

- ◆ Medicare does have an NCD regarding Intracranial PTA/Stenting

www.cms.hhs.gov/Transmittals/downloads/R1147CP.pdf

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- ◆ 37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; w/distal embolic protection

This code includes all ipsilateral cervical /cerebral carotid angiograms, angioplasties, and S&I codes

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- ◆ 37799-Q0 Unlisted procedure, Vascular Surgery
- ◆ Use this code for Intracranial PTA/Stenting
- ◆ The appropriate IDE number must be on the claim as well
- ◆ This code is inclusive of all components for the placement of the stent

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- ◆ There is a code for a Carotid Stent **without** the use of distal embolic protection (37216)
- ◆ This is considered “investigational” by Medicare and most private carriers
- ◆ There is no reimbursement for this service

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CAROTID PROCEDURES

- ◆ 37195 Thrombolysis, cerebral, by intravenous infusion (Carrier priced)
- ◆ 37201 Transcatheter therapy, infusion for thrombolysis other than coronary (\$273)
- ◆ 75896-26 Radiological S&I (\$64)
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- ◆ 37184 Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intra procedural pharmacological thrombolytic injection(s); initial vessel
- ◆ Procedure is pre-scheduled with a diagnosis of Thrombus usually already made AMA/CPT

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- ◆ 37186 Secondary percutaneous transluminal thrombectomy (eg. nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft including pharmacological thrombolytic injections, provided in conjunction w/ another percutaneous intervention
- ◆ This is an “Add-On” code AMA/CPT