Documentation Dissection

Pre-Procedure Diagnosis: Thrombotic left common iliac artery stenosis diagnosed by CTA of lower extremity yesterday in ED. Patient scheduled to come back today for intervention [1].

Post-Procedure Diagnosis: Severe left common iliac artery stenosis 90% s/p stenting to left common iliac artery [2].

Procedure Performed: Left common iliac artery stenting at the bifurcation [3].

Anesthesia Used: IV versed and fentanyl, local 2% lidocaine.

Estimated Blood Loss: <10 mL.

Condition: Stable.

IV Contrast Used: 100 mL Isovue 300 [4].

Complications: None.

Procedure and Findings in Detail: The procedure was described to the patient including benefits, risks, and alternatives to the procedure. The patient confirmed understanding. The patient signed the informed consent. She was brought into the lab. The bilateral groins were prepped in a sterile fashion, and a sterile drape was placed over the patient.

The left common femoral artery (CFA) was palpated and the region above the artery was anesthetized with 2% local lidocaine. A Cook needle was used to access the left CFA. The wire was visualized under fluoroscopy ascending into the common iliac artery. A 5 Fr sheath was placed over the wire without difficulty in the normal form and fashion. This was then exchanged for a 6 Fr 23 cm sheath [5].

The 0.0350 wire was loaded through a 5 mm 2 cm 130 cm ultraverse Balloon catheter. The catheter was advanced to the left common iliac artery. At the distal end of the iliac artery, the previously identified lesion was encountered. The lesion is still 90% stenosed. The lesion was crossed with the wire without any problem. Then the balloon was advanced to the site of stenosis. The lesion underwent dilatation with this balloon 2 times. Still there was significant stenosis at the lesion. The lesion was stented with self-expanding balloon expandable stent 7 37 mm Express stent in left common iliac artery without any problem. The stent was post dilated with this 7 mm 20 mm 75 cm Balloon with 0% residual stenosis. Then the balloon was removed [6]. Repeat angiogram revealed 0% residual with good flow. The 6 Fr sheath was exchanged to a short 6 Fr sheath [7].

The patient was in hemodynamically stable condition throughout entirety of the procedure. The sheath will be removed when ACT is less than 130/min and manual pressure will held for 25 min.

Findings:

Left: 90% lesion in the left common iliac s/p stenting with 7*37 mm Express stent with pre and post dilatation

Summary: Severe PVD with 90% left common iliac stenosis. Common iliac artery s/p stenting with 7 mm Express stent in Left common iliac artery with good results [8].

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[1] The pre-procedure diagnosis was obtained yesterday with a computed tomographic angiography of the lower extremity. This is important when reviewing the coding rules discussed below under CPT code.

[2] A postoperative diagnosis is noted.

[3] The planned operative procedure is provided, with the location. For endovascular procedures, it is important to note which interventions were performed in which vessels.

[4] The contrast is reported as Isovue 300. The Iodine content is 300, the volume of Isovue used is 100 ml. There is a HCPCS code for Iodine based contrast.

[5] The location (and specific details of the procedure is provided. Notice that only the left side was accessed.

[6] The location of the lesion was specified as the distal end of the iliac artery. The intervention was angioplasty and then stenting of the iliac artery. This portion of the procedure shows the details of where the catheter was moved. The type and location of the stents is provided.

[7] Follow-up angiography was performed. For revascularization procedures of the lower extremity, all imaging, pre, during, and post intervention are included in the code assignment. Do no code separately.

[8] An impression is provided. It matches the preoperative diagnosis.

What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 37221

ICD-10-CM Code: I70.202

Rationales:

CPT®: To find this procedure, turn first to the CPT Index and look for Revascularization. Subterms listed include Artery, and the sites. Select the Iliac with the listing of 37220–37223.

There are up to three vessels within the iliac region that can be treated within the same surgical session, report 37220 or 37221 for the initial vessel treated within one leg and 37222 and 37223 for other vessels when treated. 37222–37223 are specific to additional vessels treated, not separate lesions within the same vessel.

The surgeon first performed an angioplasty of the vessel with the balloon by dilating the balloon two times. After the balloon angioplasty there was still significant stenosis. So the surgeon then stented the lesion. In the coding hierarchy for the lower extremity, stenting the vessel includes angioplasty of the vessel.

If arteries in the lower part of the leg were treated, atherectomy includes stenting and angioplasty. Then stenting includes angioplasty. Angioplasty would only be coded if no other intervention took place in that vessel.

The left common iliac was stented. Assign code 37221 for stenting which includes angioplasty in the iliac artery. This was performed unilaterally. So one initial vessel code is assigned.

These procedures include accessing and selective catheterization of the vessel, traversing the lesion, radiological supervision and interpretation related to the vessel, embolic protection if utilized, closure of the arteriotomy, and imaging related to the completion of the procedure.

Note that there are almost two pages of coding guidelines in front of the endovascular revascularization procedures. It is very important for the coder to review all of these guidelines before assigning the CPT codes.

The CPT book guidelines for angiography give instructions not to report and angiography code at the time of an interventional procedure if a previous diagnostic test was performed. In this scenario, a CT angiogram of the lower extremities was previously performed to diagnose the 90% stenosis. Therefore, a code from 75XXX for angiography may not be reported.

ICD-10-CM: In the Alphabetic Index search for stenosis, artery, which provides the indication to see Arteriosclerosis. Note that there is no documentation stating that the artery is not native; that the patient has an ulcer, or that there is a graft already in place that has become clogged. We also do not have documentation of gangrene or intermittent claudication. Reviewing the subterms under Arteriosclerosis, we find a listing at the term Extremities (native arteries), code I70.209. If we go to the five-character code I70.20, we find that there are options for left, right, bilateral, and unspecified native arteries of the extremities. The bilateral and complete code is I70.202, Atherosclerosis of native arteries of the extremities, left leg.

Turning to the Alphabetic Index, look for Disease/peripheral. Indented under Peripheral is Arterial, and code I73.9. Go to the Tabular List and review the guidelines for category I73 and the Excludes 1 note for code I73.9. The Excludes1 note excludes

atherosclerosis of the extremities (I70.2- I70.70). Because we already assigned code I70.209, peripheral vascular disease is included in the atherosclerosis that was already assigned. Do not report I73.9.

Review the coding guidelines for section I70–I79, the guidelines instruct the coder to identify any exposure, use, or dependence on tobacco. See the instructional notes for the appropriate Z codes.

The documentation does not list any tobacco use for this patient. For this scenario, do not apply a Z code for tobacco use or dependence.