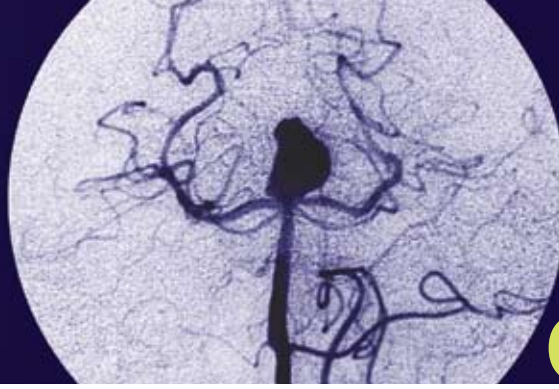


Coding and Payment Guide

Neurovascular Treatment of Aneurysms

2007



Physician Guide

The following guide provides coding and payment information for neuroendovascular repair of aneurysms for physician services. It also provides a Policy Update (below) on a significant change in Medicare hospital reimbursement for treatment of ruptured brain aneurysms. For additional details about hospital billing for these services, please consult the American Society of Interventional and Therapeutic Neuroradiology (ASITN) Hospital Inpatient Guide.

Policy Update:

Effective October 1, 2003, the Centers for Medicare and Medicaid Services (CMS) created a new Diagnosis Related Group (DRG 528) specifically for surgical and endovascular treatment of intracranial hemorrhages including those caused by ruptured aneurysms. DRG 528 was created due to an advocacy campaign championed by Boston Scientific Corporation, the ASITN, the American Society of Neuroradiology, and the Society of Interventional Radiology. Hospitals with teaching status and disproportionate share services may receive additional payments per discharge above the national average payment rate for DRG 528 (\$37,443).

Introduction

Physicians submit claims to Medicare and many private and Medicaid insurers on HCFA-1500 forms using codes such as ICD-9-CM diagnosis codes (for the documentation of medical diagnoses) and CPT® codes (for the documentation of procedures they perform).

Medicare typically reimburses physicians according to a fee schedule for each CPT code, and payment varies by geographic region. Please note that the reimbursement amounts given are specific to Medicare. Other health insurers, such as private and Medicaid, use a variety of payment mechanisms including fee schedules, percentages of allowable charges, and capitation.

The key topics addressed in this guide include:

- ICD-9-CM Diagnosis Codes
- CPT Codes
 - Rules Related to Global Periods
 - Understanding Component Coding
 - Infusion Coding
 - Evaluation and Management Services Coding
- Modifiers to CPT Codes
- Endovascular Coding Checklist



Important — Please Note: The information provided is for illustrative purposes only and is subject to change without notice. This Guide makes no express or implied warranty or guarantee concerning accuracy of codes, coverage policies, and reimbursement amounts listed. It is always the provider's responsibility to submit appropriate codes, and we strongly recommend that you consult your payer for coverage and reimbursement policies. CPT is a trademark of American Medical Association. CPT Codes ©2007 American Medical Association. All rights reserved.

ICD-9-CM Diagnosis Codes

430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
437.3	Cerebral aneurysm, nonruptured
442.81	Other aneurysm of artery of neck (e.g., aneurysm of carotid artery; excludes internal carotid artery, intracranial portion [437.3])
747.81	Anomalies of cerebrovascular system (e.g., arteriovenous malformation of brain)

CPT® Codes

Rules Related to Global Periods

This guide includes the global periods for the codes mentioned herein. These global periods are specific to Medicare. The global period specifies the number of days of care included within the global “surgical” package for a given procedure. In the case of the embolization CPT codes, 61623, 61624, and 61626, for example, there is a 0-day global period. This means that included in the payment for these codes is the related preoperative visit the day before the endovascular intervention, but post-operative follow-up may be billed separately.¹

Understanding Component Coding for Interventional Neuroradiology Services

In contrast to coding in other specialties such as neurosurgery, physicians bill for endovascular procedures using component coding — they document each significant aspect of the neurovascular procedure rather than billing a single code to describe an entire procedure such as in surgery. Basically, this means that they code for the following components of the endovascular repair: catheterization, the intervention itself, and radiological supervision and interpretation.

Catheterization

Identify all catheter introduction sites and all the vessels catheterized within the medical report. Code according to the highest order vascular family catheterized. This means identifying the final destination of catheterization, whether it is a first-order, second-order, or third-order in a vascular family. Also, report any additional second or third-order vessels catheterized in a vascular family (e.g., code 36218). Possible catheterization codes are below.

CPT Codes		2007 Medicare National Average Payment	Medicare Global Period ²
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	\$ 232	XXX
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	\$ 260	XXX
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	\$ 313	XXX
36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	\$ 50	ZZZ

¹ Medicare Carriers Manual, §4820-4829, definition of a global surgical package.

² “XXX” means Medicare’s global concept does not apply; “ZZZ” means code is part of another service and falls within the global period for other service.

Sources: International Classification of Diseases, 9th Revision, Clinical Modification.

December 1, 2006 Federal Register: Medicare rates calculated using 2007 conversion factor of \$37.8975 and a mandated budget neutrality work adjuster of 0.8994.

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Understanding Component Coding for Interventional Neuroradiology Services (Continued)

Intervention

Document the actual endovascular intervention — the insertion of implants for embolization of the intracranial or extracranial aneurysms. Possible embolization codes are below. Note that codes 61624 or 61626 are generally billed only once per aneurysm, regardless of the number of implants that are inserted within an aneurysm.

CPT Codes		2007 Medicare National Average Payment	Medicare Global Period ¹
61623	Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post-occlusion ²	\$ 525	000
61624	Transcatheter permanent occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	\$ 1,016	000
61626	Transcatheter permanent occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)	\$ 816	000

Radiological Supervision and Interpretation

Document all the vessels visualized. Components for coding include a pre-therapeutic angiography, interventional radiological supervision and interpretation, and follow-up angiography. Possible codes are listed below.

CPT-4 Codes		2007 Medicare National Average Payment	Medicare Global Period ¹
Pre-therapeutic Angiography			
75665 (-26) ³	Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation	\$ 65	XXX
75671 (-26)	Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation	\$ 80	XXX
Interventional Radiological Supervision and Interpretation (for either 61624 or 61626)			
75894 (-26)	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	\$ 64	XXX
Follow-up Angiography (Post Embolization)			
75898 (-26)	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	\$ 80	XXX

¹ "XXX" means Medicare's global concept does not apply.

² Note that CPT code 61623 includes the selective catheterization and radiological supervision and interpretation, which therefore should not be coded separately.

³ (-26) is a modifier for the professional component. Please see section on Modifiers.

Source: December 1, 2006 Federal Register: Medicare rates calculated using 2007 conversion factor of \$37.8975 and a mandated budget neutrality work adjuster of 0.8994.

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CPT® Codes (Continued)

Infusion Coding

If the case requires the infusion of a thrombolytic agent, possible codes are listed below.

CPT Code		2007 Medicare National Average Payment	Medicare Global Period ¹
Thrombolytic Infusion			
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	\$ 275	000
Supporting Radiological Supervision and Interpretation			
75896 (-26) ²	Transcatheter therapy, infusion, any method (e.g., thrombolysis other than coronary), radiological supervision and interpretation	\$ 64	XXX

Evaluation and Management Services Coding

Physicians also are entitled to bill for certain evaluation and management services, if supported by medical necessity, and it should be well-documented. According to the global period of the embolization procedure (0-day), physicians may be able to code for each subsequent day of care following the interventional procedure. Note that evaluation and management on the day of the procedure generally is not separately payable.

Possible codes are in the table below. Please note that physicians may also bill for critical care services (e.g., CPT codes 99291 and 99292), if medically necessary, but hospitals may restrict this privilege to certain specialties.³ There are also consult codes in cases where the physician performing the embolization is not the attending physician caring for the patient (such as CPT codes 99251 through 99255 for an initial inpatient consultation), which usually requires a written request from the referring physician.

CPT Codes		2007 Medicare National Average Payment	Medicare Global Period ¹
99231	Subsequent hospital care, per day, for the evaluation and management of a patient (low complexity)	\$ 36	XXX
99232	Subsequent hospital care, per day, for the evaluation and management of a patient (moderate complexity)	\$ 64	XXX
99233	Subsequent hospital care, per day, for the evaluation and management of a patient (high complexity)	\$ 91	XXX
99238	Hospital discharge day management; 30 minutes or less	\$ 66	XXX
99239	Hospital discharge day management; more than 30 minutes	\$ 95	XXX

¹ "XXX" means that Medicare's global concept does not apply.

² (-26) is a modifier for the professional component. Please see section on Modifiers.

³ "Understanding Critical Care Billing," Veronica Chiang, MD, and Issam Awad, MD, Cerebrovascular Section Newsletter, Winter 2001, pages 11–13. Source: December 1, 2006 Federal Register: Medicare rates calculated using 2007 conversion factor of \$37.8975. and a mandated budget neutrality work adjuster of 0.8994.

Modifiers to CPT® Codes

Background

Please note that physicians also must bill certain modifiers, as appropriate, to describe unique aspects of the procedure. These are two-digit hyphenated numbers or letters added to CPT codes to specify a particular circumstance. The use of these modifiers varies by health insurer. For example:

Modifier (-26): Professional Component

Indicates the professional aspect of the procedure, which applies to certain codes such as radiological supervision and interpretation. This modifier is used on physician claims.

Modifier (-51): Multiple Procedures

Certain procedures are subject under Medicare to multiple payment reduction when billed the same day. The most significant procedure (that is subject to the -51 modifier) is paid in full, and each subsequent procedure, (that is subject to this modifier), is billed with modifier -51, and payment is reduced by 50%. List the primary procedure first on the claim, then append modifier -51 to subsequent relevant code(s).¹ CPT codes subject to the -51 modifier include the endovascular codes (61623, 61624 and 61626), the catheterization codes (36215 through 36217), and the thrombolytic infusion code (37201).

Modifier (-59): Distinct Procedural Service

Used to describe a procedural service, distinct from others performed that day, which is not normally reported the same day.² For example, physicians may bill 61624 only once for a single aneurysm, regardless of the number of implants used. However, if they occlude an additional aneurysm that day, some health insurers may allow them to bill 61624 again, but with modifier -59 to indicate a distinct additional procedure was performed. Please consult your local insurer for further instruction.

Level II Modifier (-LT): Left Side

Identifies procedures done on the left side of the body. The use of this modifier depends on your local insurer.

Level II Modifier (-RT): Right Side

Identifies procedures done on the right side of the body. The use of this modifier depends on your local insurer.

Endovascular Coding Checklist

To receive appropriate payment, remember to code for the key components of the neuroendovascular aneurysm repair procedure, including use of modifiers (where needed):

- The Selective Catheterization
- The Intervention (the Endovascular Repair)
- The Radiological Supervision & Interpretation
- Any Medically Necessary Thrombolytic Infusion
- Any Medically Necessary Evaluation and Management

¹ 2002 Coders' Desk Reference, St. Anthony Publishing, 7th Edition ©2001 Ingenix, Inc., page 19.

² 2002 Coders' Desk Reference, St. Anthony Publishing, 7th Edition ©2001 Ingenix, Inc., page 20.

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