A Vascular Surgeon's Guide to Coding, Documentation and Upcoming Changes

Francesco Aiello, MD
Georgia Vascular Society
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Disclosures

• Cook Consultant
Overview

• Professional Billing
  – Modifiers
  – Procedural Coding
    • Common coding mistakes
    • “New” codes
    • Case Scenarios
  – Consult Coding
    • E/M Services

• Inpatient Documentation

• More Case Scenarios
Modifers

Used in conjunction or as a result of your codes

– **Modifier 22**
  • Tough case

– **Modifier 24**
  • Unrelated EM service

– **Modifier 25**
  • Significant & separate same day
  – Minor Surgical procedure

– **Modifier 57**
  • Decision for Surgery

– **Modifier 58**
  • Staged Procedure

– **Modifier 59**
  • Distinct procedure

– **Modifier 62**
  • Two Surgeons

– **Modifier 78**
  • Unplanned return to the OR

– **Modifier 79**
  • Unrelated return to the OR

– **Modifier 80/82**
  • Assistant surgeon
RVU

• Procedural Coding has three components
  – Pre-procedure
  – Intra service
  – Post procedure

• Multiple Procedure Payment Reduction (MPPR)
  – All subsequent codes paid 50% of value unless:
    • Supervision and Interpretation (SI) or Add-on code

• Global periods
  – 0, 10 and 90
Common Coding Mistakes

• Document Catheter placement…not Wire
  – US guided access (need storage of image)

• Diagnostic Imaging for Lower Extremity Interventions can be billed
  – Radiology Transcatheter Procedures Guidelines

• Lysis cases
  – Catheter placement and necessary imaging
  – Cessation of therapy
Common Coding Mistakes

• Thromboendarterectomy at site of bypass or aneurysm repair is not separately reportable

• Endarterectomy of Contiguous Vessel; Report ONE code
  - SFA>Iliofemoral>Profunda>common femoral
  - Complex repair and vein patches are inclusive
  - Embolectomy?

• EVAR with Fem-Fem bypass
  – 34812-50
  – +34813

Common Coding Mistakes

• Abdominal and Lower Extremity Angiogram
  – 75625, 75630-Abdominal Aortograms
  – 75710, 75716, +75774-Extremity Angiograms

• Visceral Angiogram
  – 75726-do not code abdominal aortogram also

• Renal catheter
  – 36245-intervention only
  – 36251-diagnostic and intervention
Physician Fee Schedule Search

Search Results [1 Record(s)]

Selected Criteria:
- Year: 2016
- Type of Info.: All
- HCPCS Criteria: Single HCPCS Code
- Locality: 1421299 Rest of Massachusetts
- MAC Option: Specific Locality

Single HCPCS Code

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<th>Description</th>
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</tbody>
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For your convenience, search results can be printed, downloaded or emailed.

View Items Per Page: 10  Go
New Codes-EVAR

• EVAR codes
  – 20 codes
    • 15 new codes

• Based on Anatomy and not Docking limbs
  – Endovascular Rupture codes
  – Renal arteries to Hypogastric arteries
  – More access and conduits
  – Percutaneous access and closure
  – Fixation Devices
New Codes-EVAR

• Ruptured and Non-Ruptured
  – Tube Graft
  – Aorto uniiliac
  – Aorto Biiliac
  – Iliac artery aneurysm
  – Extensions (same setting or delayed)

• Access (direct or conduit)
  • Brachial*, Axillary, Subclavian, Femoral, Iliac

• Non-billable
  – Supervision and Interpretation
  – Catheter Access
Vein Treatment

• Radiofrequency ablation (RFA)
• Endovenous laser treatment (EVLT)
• Mechanochemical Ablation (MOCA)
New Codes-Veins

• Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate); first vein treated
  – each through separate access sites

• Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate; single incompetent extremity truncal vein
  – multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
Fistulagrams

- Fistulagram
  - Fistulagram with angioplasty of peripheral
  - Fistulagram w/ angioplasty and stent of peripheral
- Thrombectomy
  - Alone
  - With angioplasty
  - With angioplasty and stent
- Add-on codes
  - Central angioplasty
  - Central Stent
  - Coil embolization of side branches
Newer Technology

- Iliac branch Device
  - T codes (0254T, 0245T)
- Fenestration
  - Fenestration
  - Scallop
Procedure Examples

• Aortobifem repair for:
  – AAA: 35081 = $1,789
  – AAA with iliac involvement: 35102 = $1,935
  – AOBF Occlusive disease: 35646 = $1,763

• EVAR:
  – Single docking limb: 34802 = $1,279
  – Two docking limbs: 34803 = $1,323
  
    • Femoral artery exposure: 34812 = $343 /2
    • Extensive repair*: 35226 = $854 /2
    • Catheter access to the aorta: 36200-50 = $233.10 /2
Case Scenarios

• Patient presents to the ER with a cold leg and dusky forefoot. Previous fem-AK pop with prosthetic, now occluded. Good Caliber GSV…Off to OR
  – Consult Service-57= $206
  – Perform a fem-pop bypass with vein = 35556 = $1,440
    • Endarterectomy at site of bypass = 0
    • Completion Angiogram = 0
    • Redo bypass -+ 35700 = $156.08
  – Poor inflow with iliac occlusion, so Iliac Stent-59
    • 37221 = wRVU = $521.81…MPPR…$260.91
Case Scenario

• Follows up two weeks later with a patent bypass but had a TIA. US shows high grade stenosis
  – Clinic visit-24
  – CEA-79

• Follows up a month later with a patent bypass but gangrenous toes 1-5
  – Clinic Visit-24
  – TMA-79
Scenario

• 2 months from original presentation, patient complains of pain in calf with ambulation
  – Duplex reveals a drop in ABI but stent poorly visualized
  – Angiogram reveals high grade stenosis at distal anastomosis
    • Decide to intervene and Treat with angioplasty
      – 75710, 37224
  – Angiogram of the Aorta then move catheter to look at LLE?
  – Angiogram of the Aorta, pelvis and LLE w/o moving the catheter?
What If No Value Assigned?

Physician Fee Schedule Search

Search Results [0 Record(s)]

Selected Criteria:
- Year: 2016
- Type of Info.: All
- HCPCS Criteria: Range of HCPCS Codes
- MAC Option: Specific Locality
- HCPCS: From: 34841 To: 34848
- Modifier: All Modifiers
- Locality: 1421299 Rest of Massachusetts

Update Results

Range of HCPCS Codes

You chose to perform a search based on a range of HCPCS codes. To minimize the volume of results, users may search by a single HCPCS code or by a list of up to five individual HCPCS codes.

Print Results  Download Results  Email Results

For your convenience, search results can be printed, downloaded or emailed.
Admissions, Consults, and Clinic Visits
A consult is a consult is a consult…

• Three Elements to all consults
  – History
  – Physical Exam
  – Medical Decision Making

• NEED ALL THREE FOR ALL CONSULTS
History

A. Chief Complaint
   – Several words or less

B. HPI

1. **Need at least 4 elements:**
   i. Location
   ii. Duration
   iii. Quality
   iv. Severity
   v. Timing
   vi. Context
   vii. Modifying factors
   viii. Associated signs and symptoms

   Patient has RLE calf/leg pain for the last 2 months that is cramping and burning in nature. This pain is made worse with minimal activity and relieved with rest.
C. Review of Systems:

i. Constitutional

ii. Eyes

iii. Ears, nose, mouth, throat

iv. Card/Vasc

v. Resp

vi. GI

vii. GU

viii. Musc

ix. Integumentary

x. Neuro

xi. Psych

xii. Endo

xiii. Hem/Lymph

10 systems!

ROS: “review of systems as per HPI. All others Negative”

-NEED to document pertinent positives and negatives!
History

D. PFSH (past, family and social history)

1. Past Medical and Surgical History
2. Family History
3. Social History

Do not use the term “Non-contributory”

Family History: No hx of PAD (this suffices)
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<tr>
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<td>A. Head/Face</td>
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<td></td>
<td>B. Eyes</td>
<td>B. Neck</td>
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<tr>
<td></td>
<td>C. Ears, Nose, Mouth, throat</td>
<td>C. Back</td>
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<td></td>
<td>D. Cardiovascular</td>
<td>D. Abdomen</td>
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<td>E. Respiratory</td>
<td>E. Chest, Breast, axilla</td>
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<td>F. Gastrointestinal</td>
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<td>G. Genitourinary</td>
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<td>L. Heme/lymph</td>
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Example Exam**

PHYSICAL EXAMINATION:

GENERAL: This is a pleasant woman who appears her stated age.

VITAL SIGNS: Weight is 183 pounds with BMI of 33, heart rate 94 BPM and regular, blood pressure 142/57 mmHg.

HEENT: Sclerae are anicteric. There are no ocular xanthelasma.

NECK: Jugular venous pressure is normal. Carotid upstrokes are normal. No carotid bruits are heard.

LUNGS: Clear to auscultation bilaterally with no rales or wheezes.

HEART: Regular S1 and S2, normal intensity. No murmurs heard. No S3 gallop is heard.

EXTREMITIES: There is no edema. Peripheral pulses are normal. Lower extremity venous varicosities are noted.

NEURO: A&O x3 with normal speech.

PSYCH: Normal affect.

Nine line items, but six organ systems noted.

Constitutional = General/Vitals
Eyes = Ocular findings
Cardiovascular = Neck findings, Heart, Extremities
Respiratory – Lungs
Neurologic = Neuro
Psychiatric = Psych

? ENT – Moist mucus membranes, no oral lesions
? Skin – No jaundice, rashes or ulcers
? Lymphatic – No LAD
A/P:
65 year old male with history of PAD now presents with acute limb ischemia. CTA personally reviewed and shows occluded bypass graft. Will start on Heparin drip with close monitoring of PTT. Discussed care with patients son as well as ER physician and plan for emergent surgery.

- Discussion with Primary team or ER physician
- PLAN!
  - Meds, Surgery, End-of-Life discussion
### New Patient Office Visit (3 out of 3)

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### Established Patient Office Visit (2 out of 3)

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### Initial Hospital Care (3 out of 3)

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New Patient Office Visit (3 out of 3) Established Patient Office Visit (2 out of 3)

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Select the code # with 3 circles across. Or select the code # next to the circle closest to the top. Select the code # with 2 or 3 circles across. Or select the code # next to the 2nd circle from top to bottom.

Initial Consultations (3 out of 3) Initial Hospital Care (3 out of 3)

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</tbody>
</table>

Select the code # with 3 circles across. Or select the code # next to the circle closest to the top. Select the code # with 2 or 3 circles across. Or select the code # next to the 2nd circle from top to bottom.

Subsequent Hospital Care (2 out of 3) Emergency Department Visits (3 out of 3)

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
<th>Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>Prob Focused</td>
<td>Prob Focused</td>
<td>Straight/Low</td>
<td>15</td>
<td>99281</td>
<td>Prob Focused</td>
<td>Prob Focused</td>
<td>StraightF</td>
<td>N/A</td>
</tr>
<tr>
<td>99232</td>
<td>Expanded PF</td>
<td>Expanded PF</td>
<td>Moderate</td>
<td>25</td>
<td>99282</td>
<td>Expanded PF</td>
<td>Expanded PF</td>
<td>Low</td>
<td>N/A</td>
</tr>
<tr>
<td>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
<td>35</td>
<td>99283</td>
<td>Expanded PF</td>
<td>Expanded PF</td>
<td>Moderate</td>
<td>N/A</td>
</tr>
<tr>
<td>99238</td>
<td>Discharge Day Mgmt.- 30 Min. or Less</td>
<td></td>
<td></td>
<td></td>
<td>99284</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
<td>N/A</td>
</tr>
<tr>
<td>99239</td>
<td>Discharge Day Mgmt.- &gt; 30 min.</td>
<td></td>
<td></td>
<td></td>
<td>99285</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Level 3 versus Level 4

- Inpatient Consult

Select the code # with 3 circles across. Or select the code # next to the circle closest to the top.

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>Prob Focused</td>
<td>Prob Focused</td>
<td>Straight F</td>
<td>20</td>
</tr>
<tr>
<td>99252</td>
<td>Expanded PF</td>
<td>Expanded PF</td>
<td>Straight F</td>
<td>40</td>
</tr>
<tr>
<td>99253</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
<td>55</td>
</tr>
<tr>
<td>99254</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>80</td>
</tr>
<tr>
<td>99211</td>
<td>Physician Presence Not Required</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>99212</td>
<td>Prob Focused</td>
<td>Prob Focused</td>
<td>Straight F</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded PF</td>
<td>Expanded PF</td>
<td>Low</td>
<td>30</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
<td>45</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td>60</td>
</tr>
</tbody>
</table>

Initial Inpatient Consultations (3 out of 3)
Consults, Rounding...

- **Consults-Admits**
  - Level 1: 1.92
  - Level 2: 2.61
  - Level 3: 3.86

- **Rounding**
  - Level 2: 1.39

Let's place this in perspective:

**Vascular Surgeon A:** 1100 clinic visits/year

- Established 750: Level 3 → 4: +400 wRVU
- Consults: 100: level 1 → 3: +200 wRVU

**Total RVU:** 600 RVU

**29 Carotid Endarterectomies!**

- **Clinic-Established:**
  - Level 3: 0.97
  - Level 4: 1.50
CMS may overhaul E/M coding; history (and exam) may be history

Brace for a big shake-up to E/M coding. CMS announced its intention to pursue “comprehensive reform of E/M documentation guidelines” in the 2018 proposed Medicare physician fee schedule released July 13.

Citing two elements of E/M coding as especially burdensome to providers – history and physical exam – The agency states that “medical decision-making [MDM] and time are the more significant factors” weighing on a given level of E/M service.

“As long as a history and physical exam are documented and generally consistent with complexity of MDM, there may no longer be a need for us to maintain such detailed specifications for what must be performed and documented for the history and physical exam,” states the agency.

Comments are due no later than Sept. 11. Once the rule is published, comments can be submitted through www.regulations.gov.
## Diagnosis Coding Made Somewhat Easy

### Vascular Surgery ICD-10 Codes

<table>
<thead>
<tr>
<th>CEREBROVASCULAR DISEASE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-10 Code</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>I65.2</td>
</tr>
<tr>
<td>I65.21</td>
</tr>
<tr>
<td>I65.22</td>
</tr>
<tr>
<td>I65.23</td>
</tr>
<tr>
<td>I65.29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occlusion and stenosis of carotid artery with cerebral infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-10 Code</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>I63.031</td>
</tr>
<tr>
<td>I63.032</td>
</tr>
<tr>
<td>I63.033</td>
</tr>
<tr>
<td>I63.231</td>
</tr>
<tr>
<td>I63.232</td>
</tr>
<tr>
<td>I63.239</td>
</tr>
<tr>
<td>I63.131</td>
</tr>
<tr>
<td>I63.132</td>
</tr>
<tr>
<td>I63.139</td>
</tr>
</tbody>
</table>

### Signs and Symptoms of Carotid Disease

<table>
<thead>
<tr>
<th><strong>ICD-10 Code</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>R47.81</td>
<td>Slurred Speech</td>
</tr>
<tr>
<td>R29.5</td>
<td>Transient paralysis</td>
</tr>
<tr>
<td>G45.3</td>
<td>Amaurosis Fugax</td>
</tr>
<tr>
<td>G81.01</td>
<td>Flaccid hemiplegia affecting right dominant side</td>
</tr>
<tr>
<td>G81.02</td>
<td>Flaccid hemiplegia affecting left dominant side</td>
</tr>
<tr>
<td>G81.03</td>
<td>Flaccid hemiplegia affecting right nondominant side</td>
</tr>
<tr>
<td>G81.04</td>
<td>Flaccid hemiplegia affecting left nondominant side</td>
</tr>
</tbody>
</table>

### Dissection of Carotid Artery

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<th><strong>ICD-10 Code</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>I77.71</td>
<td>Dissection of carotid artery</td>
</tr>
</tbody>
</table>
Medical Center Finances

Why Should I care?
Documentation is imperative to reimbursement and quality metrics: Hospital Inpatient Quality Report (IQR) and Hospital Compare

The measures adjust for **case mix differences** among hospitals based on the clinical status of the patient at the time of the index admission. Accordingly, only comorbidities that are present at that time or in the 12 months prior, and not complications that arise during the course of the hospitalization, are included in the risk adjustment.

**CMI: Case Mix Index**
Diagnosis

• Specific
  – Acute, chronic or acute on chronic
  – Chronic…complete
  – Location location location

• Present on Arrival (POA)
  – Quality and financial
    • Hospital acquired conditions (HAC)

• Clinical Significance
  – Expected (ileus…)
  – Acute post operative blood loss anemia
Linking Diagnosis

• Diabetes
  – Neuropathy
  – Ulcer

• Atherosclerosis
  – Gangrene

• Electrolytes
  – Need a reason to check
MACRA

- MACRA creates Medicare reimbursement models based on quality and outcomes. It is not based upon volume.
- Two programs for physician reimbursement:
  - Merit-based Incentive Payment System (MIPS)
    - Composite Performance Score (CPS) calculated based on 4 components
      - Quality
      - Improvement Activities?
      - Advancing Care Information
  - Cost
  - Alternate payment Model (APM)
    - No current models for vascular surgery
Thank you

Questions??
Scenarios

- Angiogram w/ angioplasty of the BK-POP and SFA stent
  - 37226

- Angioplasty and Stent of the Common iliac artery and angioplasty of the external iliac artery
  - 37221, +37222

- Stent of the Common iliac artery and External Iliac artery
  - 37221, +37223

- Aortogram with catheter in same position, bilateral LE angiogram. Atherectomy and stenting of the
Scenarios

• Angiogram of aorta, move catheter to distal aorta and image LLE. Placement into Right CFA for selective imaging of SFA and POP. Angioplasty and stent of the SFA with angioplasty of the AT and PT.
  – 75625, 75710
  – 37226, 37228, +37232

• Same as above but notice distal emboli and use suction embolectomy…
Scenarios

• Common femoral endarterectomy. Stick patch and attempted SFA stent, unsuccessful. CFA to AK-pop bypass with ptfe?
  – 35656

• Femoral Endarterectomy of the EIA, CFA and Profunda
  – 35355

• Bypass revision…
  – Thrombectomy?
  – Excision of infected graft?
Scenarios

• FEVAR with fenestrations to the Renal arteries and SMA Scallop
  – 34842 or 34846
    • SMA catheterization and stenting
      – 34842/34846 and 36245, 37236

• Iliac artery aneurysm repair w/wo occlusion of IIA
  – 34900
  – 34900 w/ 34808–36246, 37242

• Iliac branch Device
  – 0254T, 0255T
Scenarios

• TEVAR w/o coverage of the subclavian artery
  – 33881
    • Proximal extension x 2
      – 33881, 33884, 33884
    • Proximal Extension and coverage of the subclavian artery
      – 33881 33880
  • Placement of a distal extension
    – 0 (unless in a delayed setting=33886)
  • Open exposure of the femoral artery
    – 34812
      » Extensive repair
      » 35226 (prosthetic patch=35286)
Subsequent Hospital Care

DAILY NOTES

• SOAP!!
• Subjective
  – Need an element of HPI ➔ Why is the patient here?!
  – Patients abdominal pain improved overnight and able to tolerate sips. Denies any fevers, chills, N/V, diarrhea.
  – This may count as HPI and ROS!!
• Objective
  – Physical Exam
• Assessment and Plan
  – NO EVENTS O/N
  – Do not need a PFSH

Subsequent Hospital Care (2 out of 3)

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<td>Detailed</td>
<td>High</td>
<td>35</td>
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Rest of Georgia
99231: $38.76
99232: $71.15

Atlanta
99231: $39.88
99232: $73.28