## Interventional Radiology of the Upper Extremities

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### Upper Extremities Interventional Radiology Coding Tips

If performing interventional procedures in addition to diagnostic angiography, it may be appropriate to charge separately for each portion of the study. See the CPT Manual for guidelines associated with each code to determine when diagnostic angiography may be separately coded.

CPT defines the segments of the dialysis circuit as follows:

**Peripheral dialysis segment:** The peripheral dialysis segment is the portion of the dialysis circuit that begins at the arterial anastomosis and extends to the...
Central dialysis segment: The central dialysis segment includes all draining veins central to the peripheral dialysis segment. In the upper extremity, the central dialysis segment includes the veins central to the axillary and cephalic veins, including the subclavian and innominate veins through the superior vena cava. In the lower extremity, the central dialysis segment includes the veins central to the common femoral vein, including the external iliac and common iliac veins through the inferior vena cava.

Also, the most current information pertaining to CCI instructions relative to this topic can be found in the January 2017 NCCI Manual at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

1. Code to the highest order in each vascular family for final catheter placement. Access into AVF/AVG for diagnostic imaging only is defined by CPT 36901. However, when an intervention is performed in the peripheral segment of the dialysis circuit, diagnostic imaging is included and not reported separately.

2. Assign one procedure code regardless of the number of studies per operative field or site. However, multiple fields qualify as multiple sites.

3. New angioplasty codes 37246 (first artery) and 37247 (each additional artery) include imaging guidance necessary to perform and document completion of the procedure. Do not report a separate S & I code. Angioplasty is charged only once per vessel regardless of the number of lesions treated in the same vessel. Multiple angioplasty charges may be submitted when separate and distinct lesions are treated in separate vessels outside of the dialysis circuit.

4. Therapeutic interventions within the peripheral segment of the dialysis circuit are built upon a hierarchy of increasing service. Angioplasty, if the only therapeutic intervention, is reported with 36902. Stent placement in the peripheral segment is reported with code 36903 and includes angioplasty if performed. Mechanical thrombectomy and/or infusion for thrombolysis within any portion of the dialysis circuit is reported by 36904. If angioplasty is performed in addition to mechanical thrombectomy/thrombolysis, report 36905 instead of 36904. If stent placement in the peripheral segment is performed in addition to mechanical thrombectomy/thrombolysis, report code 36906 instead of 36904 or 36905. Code 36906 includes angioplasty if performed. All codes include diagnostic and completion angiography, so do not additionally assign code 36901.

5. No selective or non-selective catheterization code is necessary when submitting code 75898. For intracranial or spinal cord procedures, use this code per follow-up angiogram performed with embolization services. Do
not assign code 75898 when performing completion angiography post angioplasty, intravascular stenting, thrombolytic therapy, thrombectomy, non-intracranial/non-CNS/non-head or neck embolization or atherectomy. This code (75898) is submitted only once when extracranial embolization is performed, regardless of the number of separate vessels treated and subsequently injected.

6. Mechanical thrombectomy by any method and/or thrombolytic infusion within the dialysis circuit is reported with code 36904 unless angioplasty or stent placement is also performed in the peripheral segment of the circuit. In those cases, report 36905 (angioplasty), or 36906 (stent placement including angioplasty if performed). Removal of the arterial plug using a balloon catheter is considered a type of mechanical thrombectomy and not an angioplasty.

7. Codes 37202 and 75896 for non-thrombolytic infusion have been deleted. If a true infusion (not slow push injection) is performed with a non-thrombolytic pharmacologic agent such as Priscoline or Verapamil, consider reporting unlisted code 37799.

8. Interventions in the central segment of the dialysis circuit are reported with add-on codes 36907 and 36908 plus a primary code from 36901–36906. Report code 36907 when one or more central vein angioplasties are performed through the dialysis circuit. Report code 36908 when central vein stent placement is performed through the dialysis circuit. Code 36908 includes any angioplasties performed in the central veins at the same session as stent placement. Both 36907 and 36908 must be reported in addition to either the diagnostic fistulagram code 36901 or one of the other dialysis circuit therapeutic intervention codes 36902–36906.

9. Graft types/materials (i.e., PTFE) do not alter the coding conventions described earlier for percutaneous procedures.

10. Codes for dialysis graft fistulagram/interventions include one or more accesses into the graft circuit. Do not report codes 36901–36909 twice.

11. The dialysis circuit includes the arterial anastomosis through the central veins. The same holds true whether there is a graft between the artery and vein or an anastomosis created by transposing a native vein to a native artery. The circuit is divided into two segments. The peripheral segment begins at the arterial perianastomosis region and includes the draining veins up to the central veins. In arm fistulas, this includes through the axillary or cephalic veins. In thigh grafts, this includes through the common femoral vein. The central segment includes the draining veins, which are more central such as the subclavian vein through the SVC for arm grafts/fistulas; and external iliac and common iliac veins through the IVC for thigh grafts.
UPPER EXTREMITY (ARTERIAL) – VIA FEMORAL OR CONTRALATERAL APPROACH

L = Left
R = Right

- Subclavian
  - L 36215 / R 36216

- Deltoid
  - L 36216 / R 36217

- Anterior humeral circumflex
  - L 36216 / R 36217

- Proximal brachial
  - L 36216 / R 36217

- Radial collateral
  - L 36217 / R 36217
  - Superior ulnar collateral
    - L 36217 / R 36217

- Axillary
  - L 36215 / R 36216

- Common interosseous
  - L 36217
  - R 36217

- Posterior interosseous
  - L 36217
  - R 36217

- Anterior interosseous
  - L 36217
  - R 36217

- Radial
  - L 36217
  - R 36217

- Ulnar
  - L 36217 / R 36217

- Superficial palmar branch of radial
  - L 36217
  - R 36217

- Deep palmar arch

Most commonly used S&I codes are:

- **75710**  - Angiography, extremity, unilateral, radiological supervision and interpretation
- **75716**  - Angiography, extremity, bilateral, radiological supervision and interpretation
- **+75774**  - Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)