ICD10monitor

Cardiovascular and Vascular Interventional Radiology Specialization Improves Coding Performance

By Kristi Pollard, RHIT, CCS, CPC, CIRCC, AHIMA-Approved ICD-10-CM/PCS Trainer

A deep dive into the "toughest type of coding.

While you may have dedicated CPT® coders for interventional cardiology (IC) and vascular interventional radiology (VIR) for outpatient coding, you may not have considered the importance of doing the same for inpatient ICD-10-PCS coding.

These intricate procedures are extremely difficult to understand and visualize. I often tell people that VIR CPT coding is the toughest type of coding. Accurate coding of these cases requires professionals who truly understand the procedures and vascular anatomy.

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We already have a workforce trained in this specialty, but in a different coding system: CPT. In fact, according to one of my clients who employs specialty IC and VIR coders for CPT coding, these specialists are being pulled into discussions about PCS coding to offer much-needed guidance. In addition, my colleagues recently tapped into my

knowledge about cardiac catheterizations for help in auditing PCS codes. So, in the interest of proper education and training to promote PCS coding integrity, this article explores requirements that extend beyond the 2018 basic guidelines regarding tubular body parts, and offers recommendations to ensure correct cardiovascular coding of IC, cardiac catheterization, and VIR procedures.

Official Guideline for 2018

> "If a procedure is performed on a continuous section of a tubular body part, code the body part value corresponding to the furthest anatomical site from the point of entry.
>
> Example: A procedure performed on a continuous section of artery from the femoral artery to the external iliac artery with the point of entry at the femoral artery is coded to the external iliac body part."
>
> - 2018 ICD-10-PCS Official Guidelines for Coding and Reporting, guideline B4.1c
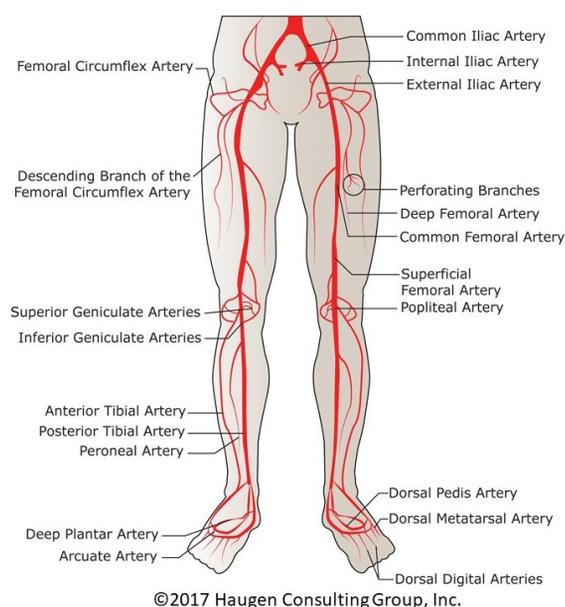
Knowing how these vascular procedures are performed is critical to choosing the correct body parts on the vascular codes. According to the new guideline, coding a procedure on a continuous section of a tubular body part requires considering two different body parts. For example, there's a continuous vessel in the leg – the femoral artery continues into the iliac artery. If plaque is removed from the femoral artery and the iliac artery, you don't code both. Code only one: the part furthest from the starting point, from where the vascular system was accessed.

Coders are aware of coding in directional terms – distal (further away from) and proximal (closer to) – with the starting point usually at the center of the body. With the new guideline, the point of reference is not the center of the body; it is the access point where the procedure started.

An Example

When performing a VIR procedure, the access point is typically through the femoral artery. There are two femoral arteries, one on each side. If the physician "pokes" the right femoral artery and advances the catheter up toward the heart, it goes through the right external iliac artery and up into the aorta and can then go down the other leg. If the physician starts in the right femoral artery and works on a lesion that extends up into the right external iliac artery, then the body part is the right external iliac, because it's the furthest point from the point of entry. But consider that you go down the other leg, so you poke the right side and go up into the aorta and take care of a lesion on the left external iliac and the left femoral artery. In that case, your body part is the left femoral artery, because that is the most distal body part from where you started.

When coding peripheral interventions on the legs, coders need to know ipsilateral and contralateral terminology. If percutaneous transluminal angioplasty (PTA) is performed on the right external iliac and right common femoral arteries, the access site is what determines the body part character. Approaching the lesion from the right (ipsilateral) leg means the body part is right external iliac artery. Approaching the lesion from the left (contralateral) leg means the body part is the right common femoral artery.
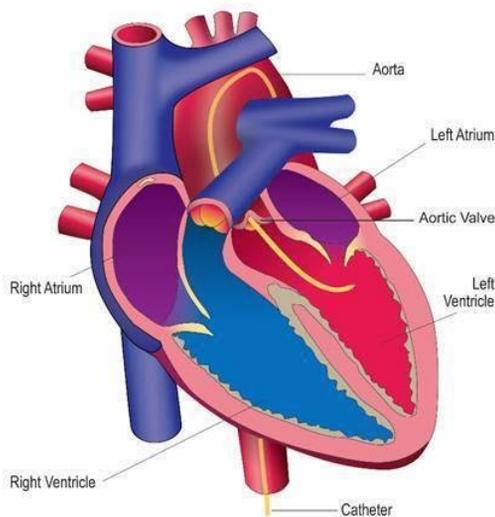

Common Iliac Artery
Internal Iliac Artery
External Iliac Artery
Femoral Circumflex Artery
Descending Branch of the Femoral Circumflex Artery
Perforating Branches
Deep Femoral Artery
Common Femoral Artery
Superficial Femoral Artery
Popliteal Artery
Superior Geniculate Arteries
Inferior Geniculate Arteries
Anterior Tibial Artery
Posterior Tibial Artery
Peroneal Artery
Dorsal Pedis Artery
Dorsal Metatarsal Artery
Deep Plantar Artery
Arcuate Artery
Dorsal Digital Arteries

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So when we code an interventional radiology procedure in CPT, we're always thinking about where our procedure started, the point
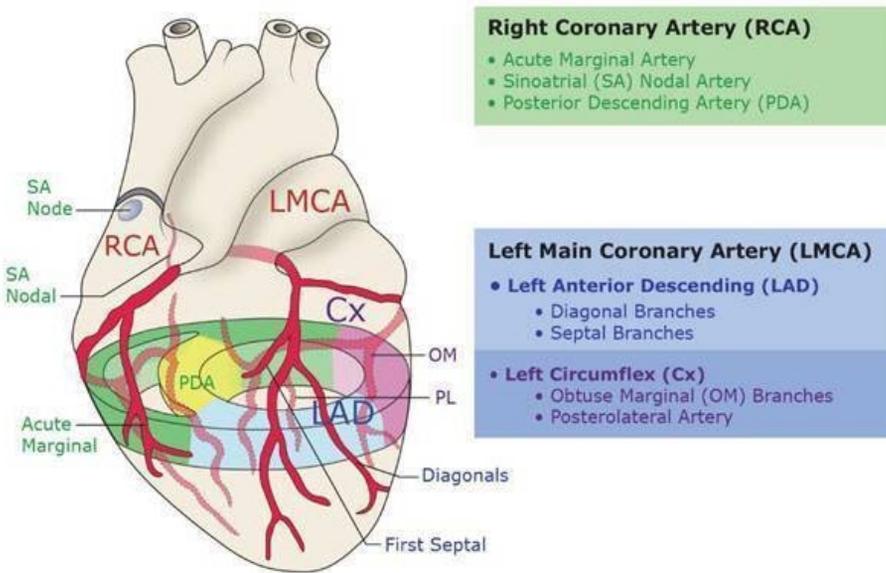
of entry where the patient vessel was punctured, and final position of the catheter. This is not the way we've thought in the past, with ICD-9 coding. It's time to get our CPT coders involved in training ICD-10-PCS coders and/or coding in PCS.

Addressing Specific Challenges: What Coders Need to Know

Another area of confusion for coders is the difference between a left heart catheterization and coronary imaging. In ICD-9, if the physician documented a left heart cath, we coded it. In ICD-10-PCS, he or she might call it a left heart cath, but never go into the heart at all. Coronary imaging can be done from the aorta without crossing the aortic valve. And just because a catheter is placed in the left side of the heart doesn't mean it's a heart cath. Heart catheterization is coded to the root operation of measurement in PCS – assigning that code requires a measurement, not just inserting a catheter into the heart.

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Right Coronary Artery (RCA)
• Acute Marginal Artery
• Sinoatrial (SA) Nodal Artery
• Posterior Descending Artery (PDA)

Left Main Coronary Artery (LMCA)
• Left Anterior Descending (LAD)
    • Diagonal Branches
    • Septal Branches
• Left Circumflex (Cx)
    • Obtuse Marginal (OM) Branches
    • Posterolateral Artery

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In addition to understanding cardiovascular anatomy, coders who are assigning PCS codes for VIR, cardiac catheterization, and IC procedures must know the following:

• Where the catheter is at all times: the location of the catheter is critical in both CPT and ICD-10 coding.

• What structures were imaged and why, based on the interpretation. For example, the physician may have injected the abdominal aorta, but the intent of the procedure was to image the renal arteries.

• When imaging is integral and when it is diagnostic. This is tough because the same imaging modality (fluoroscopy) is used for diagnostic angiography and guiding shots/roadmapping necessary to complete an intervention, such as angioplasty. CPT VIR and cardiology coders are trained to do this, based on the documentation.

• How blood is moving through the heart and vessels and what imaging is possible from certain vantage points. For example, if the catheter is placed at the aortoiliac bifurcation, with the way blood moves, the legs will be imaged, but not the aorta.

- How to validate that the documented procedure backs up the procedure the physician described. For example, the physician may say he or she did a left heart cath, but there are no heart pressures documented and the procedure description demonstrates only coronary imaging was done. Or the physician may say he or she did an aortogram with bilateral leg imaging, but there are no findings for the aorta, only the legs.

The complexity of the procedures suggests that creating specialized PCS coders for VIR/IC is as important as assigning specialized CPT coders for the same service areas, since many of these cases can be performed in the outpatient (CPT) or inpatient (PCS) healthcare settings.

Guidance to Improve Coding Performance

As we all know, productivity is a primary focus in modern healthcare. Balancing accuracy with productivity is a constant challenge, especially considering the vast number of codes and the granularity required in PCS. Helping to streamline the process through specialization can support both accuracy and productivity. If coders specialize, they better understand the procedures and how to code properly in a particular area. This is critical in cardiovascular coding. The procedures are intricate and difficult to understand.

Common practice in many organizations is to place all records, all discharges for the day, in a collective pool. Coders then code from the pool of discharges. Unfortunately, not all facilities sort cases by specialty. Doing so leads to expertise in specific areas. A "jack of all trades, but master of none" approach doesn't work well for coding difficult procedures. With the complexity of PCS, it's more important than ever that we specialize our coders; designate a cardiovascular coder, GI coder, and others to cover different areas.

I've found that my experience with VIR CPT coding comes in handy when trying to assign PCS codes to the same procedures. Coders must know and be able to visualize how procedures were performed. And they need to know the physician's intent. The good news is that we can apply many CPT principles to ICD-10.

Specialization gives coders confidence to know exactly what they're doing. Typically, in the CPT interventional radiology realm, error rates are in the 75th percentile range. Imagine a hospital CFO reporting that 75 percent of vascular interventional radiology procedures are coded incorrectly. Assigning VIR cases to inpatient coders who have been coding for many years and have no idea how these procedures are done is a problem.

What is the best strategy to improve accuracy and productivity? Organizations must ensure that coders receive education and training from professionals with experience and expertise in this highly complex area of specialty.

Here are four suggestions to improve productivity and accuracy:

- Employ specialty coders.

- Use VIR and IC CPT coders to assist in training inpatient coders – cross-train CPT and PCS coders.

- Raise awareness and promote understanding of the new coding guideline.

- Use anatomical pictures in training; this is critical to understanding anatomy.

Our team has developed a set of anatomical illustrations for training purposes. We work with a staff artist who can draw pictures for us and even create animations. Visuals make an incredible difference in understanding difficult procedures. Our coders need all the education and expertise we can offer to ensure their success heading into the new year!

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Kristi Pollard is a senior coding consultant at Haugen Consulting Group with more than 20 years of industry experience. She develops web-based and instructor-led training material and conducts training in ICD-10-CM/PCS. Kristi has an extensive background in coding education and consulting and is a national speaker

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