Percutaneous recanalization of total occlusions of the iliac vein

This manuscript presents an institution’s experience with percutaneous endovenous recanalization of symptomatic iliac vein occlusions. Over an 8 year period, they treated 167 limbs in 159 patients with femoro-ilio-caval chronic total occlusions. They conclude that this approach is minimally invasive, safe, and efficacious, as well as applicable to a broad spectrum of patients regardless of age, symptom severity, and comorbidity.

Endovascular treatment of venous occlusive disease is governed by component coding for the use of catheters, imaging, and intervention. Additionally, the manuscript describes all therapies as percutaneous with access obtained using ultrasound guidance. CPT code 76937 describes the evaluation of the veins for puncture and guidance of the needle entry during the endovenous access. Reimbursement is predicated on digital archiving or placement of a hard copy printout in the medical record in addition to the dictated angiography report.

The catheters were all inserted into the thigh femoral or deep femoral vein and then advanced in a nonselective fashion into the inferior vena cava (IVC). No selective manipulation of the catheter was performed. Use of reentry devices or cutting balloons to facilitate access into the true lumen of the IVC results in no additional coding. Therefore, CPT code 36010 is appropriate to report nonselective IVC catheterization. The authors describe bilateral venous manipulations when traversing the femoro-ilio-caval chronic total occlusion. The second catheter code is reported with a -59 modifier. This will clarify that the second cannulation was separate and distinct.

The diagnostic imaging in this series is generally ascending venography of each lower extremity followed by IVC angiography. CPT code 75820 describes a unilateral extremity venogram. It is inappropriate to report 75820 twice in this clinical scenario where both legs are assessed.

Use of CPT code 75822 depicts a bilateral imaging study. Lastly, angiography of the IVC is reported by CPT code 75825. If the patient has had prior contrast venography in this clinical condition, the diagnostic evaluation is not reportable. If no such imaging exists, the codes require use of the -59 modifier at the time of intervention to ensure appropriate reimbursement.

Third, endovascular revascularization can be accomplished through multiple recanalization efforts. If a stent is deployed percutaneously across the occlusion, CPT codes 37205 and 75960 would describe intravascular stent insertion. Each additional vessel stented is reported by CPT codes 37206 and 75960. Keep in mind that three actual stents placed in one vessel is reported to the insurance carrier as one stent. The IVC, the common iliac veins, and the external iliac veins are all separate vessels. However, unlike in the arterial tree where a CPT assistant article has clarified the external iliac artery and the common femoral artery as separate for endovascular therapy, the external iliac vein and the common femoral vein remain the same vessel at present.

Similarly, venous percutaneous transluminal angioplasty (PTA) is reported by CPT codes 35476 and 75978. Each additional vessel treated with balloon dilation is reported similarly. When the CPT codes are repeated, subsequent coding again requires the addition of the -59 modifier. If one attempts angioplasty with the intent of PTA as the sole treatment and this intervention produces a suboptimal result, CPT guidelines allow for submission of both the PTA (with the -59 modifier appended) and the stent descriptions. PTA for predilatation purposes does not meet the requirements for this “intent” rule.

Sean P. Roddy, MD
The Vascular Group, PLLC
43 New Scotland Avenue, MC157
Albany, NY 12208
E-mail: roddy@albanyvascular.com

Submitted Jun 16, 2009; accepted Jun 16, 2009.