Bundling Rules
You Can Take to the Radiologist

Consult guidance when coding these studies to ensure proper reporting.

Radiology has arguably had more than its share of bundling recently. Computed tomography (CT) scans of certain separate body parts are no longer separately payable; endovascular revascularization studies are now grouped into all-inclusive territories; and several renal angiography procedures are now all-inclusive, as well. These changes put a new value on radiology services and challenge coders and clinicians to learn new guidelines. Allow me to explain further.

Abdomen CT and Pelvis CT
Prior to 2011, computed tomography (CT) of the abdomen and CT of the pelvis could be reported, and were reimbursed, separately. CPT® 2011 created new codes (e.g., 74174 Computed tomography, abdomen and pelvis; without contrast material, 74177 Computed tomography, abdomen and pelvis; with contrast, and 74178 Computed tomography, abdomen and pelvis; without contrast material in 1 or both body regions, followed by contrast material(s) and further sections in 1 or both body regions) that bundle the procedures when performed together.

Such bundling has a significant financial impact. For example, per the 2012 Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Relative Value File, CT of the abdomen with contrast (74160 Computed tomography, abdomen; with contrast material(s)) is valued at 1.27 work relative value units (RVUs), while CT of the pelvis with contrast (72193 Computed tomography, pelvis; with contrast material(s)) is 1.16 RVUs. If reported separately, these codes total 2.43 RVUs. But when these procedures are bundled into the single code 74177 (as they have been since Jan. 1, 2011), the work RVUs are 1.82, or approximately 25 percent lower.

Abdomen CTA and Pelvis CTA
Similarly, CPT® 2012 created a single code (74174 Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing) to bundle CT angiogram (CTA) of the abdomen and of the pelvis. Previously, these procedures were coded independently of one another. As of Jan. 1, 2012, it is no longer appropriate to report these studies separately when they are performed at the same time; you must use the combined code (74174).

Endovascular Revascularization Studies
Endovascular revascularization studies (37220-37235), often done percutaneously by interventional radiologists, were bundled into all-inclusive territories with a hierarchal system in 2011. Any revascularization procedures done in the common, internal, or external iliac arteries are now considered iliac territory. The anterior tibial, posterior tibial, and peroneal are now considered tibial-peroneal territory, and any vessel in the femoral-popliteal system is considered part of that territory. Therapeutic interventions are now inclusive of the higher valued “level.” Angioplasty is the lowest valued intervention, followed by atherectomy (which is also included in the highest level, which includes stent(s) placement). Conscious sedation is also included in these bundles.

Note: For more information about bundling of interventional vascular studies, see “Master the Significant Revisions to 2011 Vascular Codes,” February 2011 Coding Edge, pages 34-37.

Renal Angiography
In 2012, renal angiography is bundled for both selective (36251-36252) and superselective (36253-36254) catheter placements; conscious sedation is included in these all-inclusive bundles. Intravascular vena cava (IVC) filter codes are also bundled this year into all-inclusive codes for insertion (37191), repositioning (37192), and retrieval (37193): 37191 Insertion of intravascular vena cava filter, endovascular approach in-

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Takeaways:
- Recent changes have bundled several services into radiology codes.
- New guidelines and reimbursement challenge coders to report accurately.
- These changes impact CT, CTA, endovascular revascularization studies, renal angiography, and AV shunts for dialysis.
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including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed.

37192 Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed.

37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed.

AV Shunts for Dialysis

Although not an outright code change or bundle, there is a lengthy narrative clarification in CPT® 2012 regarding arteriovenous (AV) shunts for dialysis. The narrative defines the AV shunt as beginning with the arterial anastomosis and extending to the right atrium. All catheter manipulations for diagnostic imaging are included in 36147 Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava). If ultrasound guidance is properly documented, +76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure) may be separately reportable. Additional work needed in the peri-anastomotic segment, defined as the short segment of artery immediately adjacent to and distal to the anastomosis, and the anastomosis itself, is also separately reportable.

Interventions performed within the AV shunt are divided into two vessel segments for coding purposes. The peripheral segment is defined as the peri-arterial anastomosis through the axillary vein. The central segment is defined as including the subclavian and innominate veins through the vena cava. Any intervention in either segment, regardless of the number of lesions treated, is coded as one intervention. For example, if multiple balloon catheters are needed to treat occlusions in the peripheral segment, the venous angioplasty (35476 Transluminal balloon angioplasty, percutaneous; venous and 75978 Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation) would be reported one time only. The AV shunt is considered to be venous, and the peri-anastomotic segment is coded as arterial. It is permissible to code for stenting work (37205 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel and 75960 Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel) once per segment.

Now that this narrative on AV shunts has been published, we as coders are responsible for adhering to the letter of the law. Consult the narrative section of the CPT® book for guidance when coding these studies, and be sure to communicate these updates and changes to your radiologists.

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