HCPro, Inc., presents

Mastering Interventional Radiology Coding: Documentation and Coding Rules for Complex Procedures

A 90-minute interactive audio conference

Wednesday, August 28, 2013

1:00 p.m.–2:30 p.m. (Eastern)
12:00 p.m.–1:30 p.m. (Central)
11:00 a.m.–12:30 p.m. (Mountain)
10:00 a.m.–11:30 a.m. (Pacific)

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Dear Program Participant,

Thank you for participating in our “Mastering Interventional Radiology Coding: Documentation and Coding Rules for Complex Procedures” audio conference, featuring speaker Stacie L. Buck, RHIA, CCS-P, RCC, CIC, and moderated by Todd Hutlock.

Our team is excited about the opportunity to interact with you directly. We encourage you to ask our experts your questions during the program. If you would like to submit a question before the audio conference, please send it to the producer, Todd Hutlock, at thutlock@hcpro.com and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to include a good cross section of questions.

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Thank you, again, for attending the HCPro program today. We hope you found it to be informative and helpful and that you will continue to rely on HCPro programs as an important resource for pertinent and timely information.

Sincerely,

Elizabeth Petersen
Vice President
HCPro, Inc.
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Please note: Continuing education credits are available for this program. For instructions on how to claim your credits, please visit the materials download page at www.hcpro.com/downloads/11470.
Agenda

I. 2013 changes for interventional radiology coding

II. Diagnostic angiography

III. Therapeutic interventions
   A. Angioplasty
   B. Stent
   C. Atherectomy
   D. Revascularization
   E. Embolization
   F. Thrombectomy
   G. Thrombolysis
   H. Dialysis access maintenance

IV. Live Q&A
Speaker Profile

Stacie L. Buck, RHIA, CCS-P, RCC, CIC

Based in Stuart, FL, RadRx provides radiology coding and consulting services to a nationwide client base consisting of hospitals, imaging centers, radiologists, billing companies, and various consulting companies.

RadRx was founded by Stacie L. Buck to assist radiology providers with the complexities of radiology coding, documentation and reimbursement.

Stacie has 21 years experience in the health care industry. During her career she served as an internal auditor and corporate compliance officer for one of the nation’s largest providers of diagnostic imaging services. Additionally she served as Vice President and Consultant for a radiology consulting firm and radiology billing company. Stacie has served in a consulting capacity for over a decade and she is a nationally sought out speaker who has presented well over 100 seminars. She has also authored articles on radiology coding and reimbursement topics for both the Journal of AHIMA and the Radiology Management: The Journal of AHRA. In addition, she serves on the editorial advisory board of several national radiology publications.

Stacie is a member of the Radiology Business Management Association (RBMA), American Healthcare Radiology Administrators (AHRA), American Health Information Management Association (AHIMA), and the Florida Health Information Management Association (FHIMA).

Stacie’s contributions to her profession have been recognized by her peers through several awards: FHIMA Distinguished Member Award, FHIMA Outstanding Professional Award, FHIMA Distinguished Service Award, FHIMA Literary Award, AHIMA Triumph Rising Star Award and the AHIMA Triumph Mentor Award.

Stacie graduated Magna Cum Laude from Florida International University earning a Bachelor of Science degree in Health Information Management and prior earned an Associate of Arts degree in Business Administration.
Exhibit A

Presentation by Stacie L. Buck, RHIA, CCS-P, RCC, CIC
Mastering Interventional Radiology Coding: Documentation and Coding Rules for Complex Procedures

An HCPro audio conference presented on August 28, 2013

Speaker

- Stacie L. Buck, RHIA, CCS-P, RCC, CIC
  - President & Senior Consultant, AHIMA Approved ICD 10-CM/PCS Trainer
  - RadRx
  - Stuart, Fla.
Mastering Interventional Radiology Coding: Documentation and Coding Rules for Complex Procedures

Presented by
Stacie L. Buck, RHIA, CCS-P, RCC, CIC
President & Senior Consultant
AHIMA Approved ICD-10-CM/PCS Trainer
RadRx

August 28, 2013

HEAD & NECK ANGIOGRAPHY
Head & Neck Angiography

• 8 new codes
  – All-inclusive codes – surgical and RS&I component
• Pay attention to introductory language in CPT

NEW

Head & Neck Angiography

• 36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated RS&I, includes angiography of the cervicocerebral arch, when performed
  – (Do not report 36221 with 36222–36226)
  – Catheter placed in aorta, not advanced any further, imaging of arch and vessel origins

• 36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated RS&I, includes angiography of the cervicocerebral arch, when performed
  – Catheter placed in innominate or common carotid, imaging of common carotids performed
Head & Neck Angiography

- 36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated RS&I, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
  - Catheter placed in innominate or common carotid, imaging of internal carotids (includes arch and common carotids when performed)

- 36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated RS&I, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
  - Catheter placed in internal carotid, imaging of internal carotids (includes arch and common carotids when performed)

Head & Neck Angiography

- 36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated RS&I, includes angiography of the cervicocerebral arch, when performed
  - Catheter placed in subclavian or innominate, imaging of vertebral (includes arch when performed)

- 36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated RS&I, includes angiography of the cervicocerebral arch, when performed
  - Catheter placed in vertebral artery, imaging of vertebral artery (includes arch when performed)
Head & Neck Angiography

- +36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated RS&I (List separately in addition to code for primary procedure)
  - (Use 36227 in conjunction with 36222, 36223, or 36224)
  - Catheter placed in external carotid, imaging of external carotid
- +36228 Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated RS&I (e.g., middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)
  - (Use 36228 in conjunction with 36224 or 36226)
  - (Do not report 36228 more than twice per side)
  - Includes any add’l second or third order catheter placement, imaging of the add’l vessels, in same primary branch of the IC, vertebral or basilar artery
  - Catheter placed in branches of internal carotid or vertebral, imaging of branches selected

Head & Neck Angiography

- Coding rules
  - The following components are included:
    - Accessing the vessel
    - Placement of the catheter(s)
    - Contrast injections
    - Fluoroscopy
    - RS&I
    - Closure of arteriotomy
    - 36221–36228 describe arterial contrast injections w/ arterial, capillary, and venous phase imaging when performed
Head & Neck Angiography

- Coding rules
  - Progressive hierarchy (36221–36226); less intensive included in more intensive service
    - Ex. 36224, 36223, 36222 (highest to lowest)
    - Ex. 36226, 36225 (highest to lowest)
  - Only 1 code from range 36222–36224 may be reported for each ipsilateral carotid territory
  - Only 1 code in range 36225–36226 may be reported for each ipsilateral vertebral territory
  - 36221 = unilateral or bilateral
  - 36222–36228 = unilateral codes

Head & Neck Angiography

- Coding rules
  - Different territories each side
    - Append -59 modifier to “lesser” code
  - Same procedure both sides
    - Bilateral carotid and/or vertebral catheterization and imaging, append -50 modifier to 36222–36228
Head & Neck Angiography

- Coding rules
  - Add on code +36227 use w/36222, 36223, or 36224
  - Add on code +36228 use w/36224 or 36226
    - Not reported more than twice per side
  - Do not use +75774 for diagnostic angiography of extracranial or intracranial cervicocerebral vessels
  - Report +75774 for upper extremities and other vascular beds during same session
  - Report 76376 or 76377 for 3D rendering
  - Report 76937 for US guided vascular access
  - Do not report 37215/37216 (cervical carotid stent) in conjunction with 36222–36224

Head & Neck Angiography

- 75650 Arch study
- 75660 Unilateral external carotid
- 75662 Bilateral external carotid
- 75665 Unilateral internal carotid
- 75671 Bilateral internal carotid
- 75676 Unilateral common carotid
- 75680 Bilateral common carotid
- 75685 Vertebral artery
Head & Neck Angiography

- Crosswalk

<table>
<thead>
<tr>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>36227</td>
<td>75660 (external carotid, uni)</td>
</tr>
<tr>
<td>36227-50</td>
<td>75662 (external carotid, bi)</td>
</tr>
<tr>
<td>36223 or 36224</td>
<td>75665 (int carotid, uni)</td>
</tr>
<tr>
<td>36223 or 36224 (50 mod)</td>
<td>75671 (int carotid, bi)</td>
</tr>
<tr>
<td>36222 or 36223 or 36224</td>
<td>75676 (com carotid, uni)</td>
</tr>
<tr>
<td>36222 or 36223 or 36224 (50 mod)</td>
<td>75680 (com carotid, bi)</td>
</tr>
<tr>
<td>36225 or 36226</td>
<td>75685 (vertebral, uni)</td>
</tr>
<tr>
<td>36221 arch study alone</td>
<td>75650 (arch study)</td>
</tr>
</tbody>
</table>

Head & Neck Angiography

- Coding example #1
  - Access is gained at the right common femoral artery. The physician advances the catheter to the left common carotid for injection. Imaging and interpretation of the left common carotid, left internal carotid, and left external carotid are performed via the LCC injection. Next he advances the catheter into the right common carotid for injection and imaging. Imaging and interpretation of the right common carotid, right internal carotid, and right external carotid are performed via the RCC injection.
Head & Neck Angiography

• Coding example #1

• 2013 codes:
  – 36223-50

• 2012 codes:
  – 36216 RCC, 36215-59 LCC, 75671 Bilateral IC, 75680 Bilateral CC

• Coding example #2

  – Access is gained at the right common femoral artery. The physician advances the catheter to the left common carotid for injection and imaging. Next he advances the catheter into the left vertebral for injection and imaging, then to the right common carotid for injection and imaging, and finally the right vertebral for injection and imaging. An interpretation is provided for all vessels catheterized.
Head & Neck Angiography

• Coding example #2
  – 2013 codes: 36222-50, 36226-50
  – 2012 codes: 36218 RCC, 36217 RV, 36216-59 LV, 36215-59 LCC, 75680 Bilateral CC, 75685 RV, 75685 LV

Head & Neck Angiography

• Coding example #3
  – Access is gained at the right common femoral artery. The physician advances the catheter to the left internal carotid for injection and imaging, followed by catheter advancement to the left external carotid for injection and imaging. Next he advances the catheter into the left vertebral for injection and imaging, then to the right internal carotid for injection and imaging, and finally the right vertebral for injection and imaging. An interpretation is provided for all vessels catheterized.
Head & Neck Angiography

- Coding example #3
  - 2013 codes: 36224-50, 36226-50, 36227
  - 2012 codes: 36217 RIC, 36218 RV, 36216-59 LIC, 36218 LEC, 36216-59 LV, 75671 Bilateral IC, 75685 RV, 75685 LV, 75660 LEC

Diagnostic Angiography & Therapeutic Interventions
Therapeutic Interventions w/Diagnostic Angiograms

- Diagnostic angiography codes should NOT be used to report services already captured through the reporting of a therapeutic transcatheter RS&I code, including:
  - Contrast injections, angiography/venography, and fluoroscopic guidance
  - Vessel measurement
  - Road mapping
  - Completion angiography/venography (except in those circumstances when code 75898 is applicable)
  - Post-angioplasty/stent angiography – this work is captured in the interventional radiologic supervision and interpretation code(s)

Therapeutic Interventions w/Diagnostic Angiography

- Diagnostic angiography performed at the time of an interventional procedure is separately reportable if:
- No prior catheter-basedangiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR
- A prior study is available, but as documented in the medical record:
  - The patient’s condition with respect to the clinical indication has changed since the prior study, OR
  - There is inadequate visualization of the anatomy and/or pathology, OR
  - There is a clinical change during the procedure that requires new evaluation outside the target area of intervention
- Diagnostic angiography performed at a separate setting from an interventional procedure is separately reported
- Diagnostic angiography performed at the time of an interventional procedure is NOT separately reportable if it is specifically included in the interventional code descriptor
CMS says ...

• *If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier -59.

CMS says ...

• ... If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier -52 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

Source: NCCI Manual Chapter 9
PTA, STENT, & AHERECTOMY
PTA, Stent, Atherectomy Coding

- PTA, stent, atherectomy codes are assigned 1x per vessel
  - If multiple stents are deployed in the same vessel, code only 1 stent placement
  - Do not code for multiple dilations of same vessel
- If two vessels are treated with one balloon inflation, one stent, code as a single vessel
- Do not assign code 75898 for studies to check results
- Administration of heparin, nitroglycerin, etc. is not separately coded

PTA, Stent, Atherectomy Coding

- Angioplasty performed solely to deploy a stent is not separately coded
- PTA may be coded with a stent in the same vessel when:
  - Primary angioplasty fails and a stent is placed
  - PTA is used to treat lesions adjacent to the stented segment
  - PTA is used to treat a complication of stenting, such as adjacent dissection tacked down with balloon
PTA, Stent, Atherectomy Coding

- Do not report an angioplasty when a positioning balloon is utilized for atherectomy
- Atherectomy is not bundled with angioplasty or stent placement in the same vessel
- Clearly document why each was performed

LOWER EXTREMITY REVASCULARIZATION
Revascularization
“Bundled” Components

- Catheterizations
- RS&I services
- Embolic protection
- Closure of arteriotomy
- Completion angiograms
- Conscious sedation

Revascularization
Separate Components

- Mechanical thrombectomy
- Thrombolysis
- Diagnostic angiograms when:
  - There is no prior catheter-based angiogram available and a full and complete diagnostic study is performed, and the decision to intervene is based on the diagnostic study; OR
  - A prior study is available, but the patient’s condition with respect to the clinical indications has changed since the prior study; OR
  - There is inadequate visualization of the anatomy and or pathology; OR
  - There is a clinical change during the procedure that requires new evaluation outside the target area of the intervention
Vascular Territories

- For lower extremity therapeutic interventions, CPT has designated three distinct vascular territories:
  - Iliac: common iliac, internal iliac, external iliac
  - Femoral/popliteal: CF, SF, DF, popliteal
  - Tibial/peroneal: anterior tibial, posterior tibial, peroneal *(Note: TP trunk is part of posterior tibial or peroneal artery)*

Code Selection

1. Determine each vessel that was treated.
2. Determine the intervention(s) performed in each vessel.
3. Determine the most extensive procedure performed. The most extensive procedure performed will determine the primary CPT code for the encounter and the appropriate add-on codes.

- The Society for Interventional Radiology has established the following hierarchy to determine the most extensive procedure. Ordered from lowest to highest:
  - Angioplasty
  - Stent
  - Atherectomy
  - Stent with atherectomy

*Note that codes are UNILATERAL and are reported as such.*
Other Considerations

- Multiple lesions in same vessel
  - Codes are reported per vessel, not per lesion
- Bridging lesion same territory
  - Treated with a single therapy, reported once with a single code
  - Ex. Stenosis extends from the common iliac artery into the proximal external iliac artery, and a single stent is placed to open the entire lesion; the procedure is coded as a single stent placement in the iliac artery

Other Considerations

- Bridging lesion two territories
  - Code selection based on the size of the lesion in each vessel and the vessel that has the most disease
  - Ex. PTA of a lesion spanning the popliteal through to the tibioperoneal trunk is performed, and the majority of the lesion is in the popliteal; the appropriate code to assign is for a PTA of the femoral/popliteal territory
  - When a single stent is placed to treat a single lesion across two territories, only one procedure code may be reported and is determined based on whether the proximal or distal end of the area treated that has the most disease
Exceptions to Bundling of Catheterization Codes

- Diagnostic angiography performed at the same time as the intervention requires a higher degree of selectivity than the one used for the lower extremity intervention
  - Ex. Contralateral extremity angiography in conjunction with a revascularization procedure (access at RCFA, revascularization of RII, catheterization and imaging of LT leg)
- Diagnostic angiography for the revascularization is performed at the same time as revascularization from a separate access
  - Ex. Catheterization of the aorta for an aortogram may be performed via a left groin puncture, yet the revascularization is performed on the right iliac via a right groin puncture

Exceptions to Bundling of Catheterization Codes

- Another catheterization is performed through the same access for another diagnostic or therapeutic procedure requiring catheterization in a different vascular bed
  - Ex. Performing a renal PTA in conjunction with a revascularization
- A separate vessel punctured for an additional access that is not part of the revascularization procedure and another vessel is selectively catheterized for another purpose
- Another procedure is performed on the same date of service at a different session
Exceptions to Bundling of Catheterization Codes

- Modifier 59 is required to designate that the selective vessel catheterization(s) reported is not the one included in the therapeutic revascularization procedure.

EMBOLIZATION, THROMBOLYSIS, THROMBECTOMY
Embolization & Occlusion Coding

- Embolization code is assigned once per operative field
  - Bilateral organs are treated via embolization; each organ is considered a separate operative field
- Diagnostic catheterizations and RS&I are reported separately in accordance with established guidelines
- Follow-up angiography, 75898 is coded separately when documented
  - Angiogram after embolization is complete
  - Control angiograms during the procedure are included with 75894

Percutaneous Mechanical Thrombectomy

- **Arterial** codes (37184–37186) differentiate primary (planned) from secondary or “rescue” procedures in an initial vessel/secondary vessel of the same vascular family
  - 37185 and 37186 are add-on (+) codes
  - 37186 is NOT to be reported with 37184 or 37185
  - Report 37186 when done before or after another percutaneous intervention (PTA, stent placement)
- **Venous** codes (37187, 37188) differentiate initial procedure from repeat procedures during the course of thrombolytic therapy
- Includes intraprocedural thrombolysis (e.g., a short infusion)
- If a prolonged thrombolytic infusion is necessary and is also performed, code separately
Primary Thrombectomy

- Fluoroscopic guidance is bundled
- The following may be coded with thrombectomy:
  - Catheter placements
  - Diagnostic studies
  - Other percutaneous interventions

Primary Thrombectomy

- Pretreatment planning
- Performance of procedure
- Postprocedure evaluation
- “Typically, the diagnosis of thrombus has been made prior to the procedure, and a mechanical thrombectomy is planned preoperatively.”

*Revised CPT 2008*
Primary Thrombectomy

- Reported per vascular family
- Initial vessel = 37184
- Second and all subsequent = 37185

Secondary Thrombectomy

- “Rescue” thrombectomy
- Removal or retrieval of short segments of thrombus or embolus when performed either before or after another percutaneous intervention (percutaneous transluminal balloon angioplasty, stent placement)
  - Do NOT report 37186 in conjunction with 37184 and 37185
Transcatheter Therapy

- 37201 deleted and replaced with 37211–37214
  - 75896 revised
  - 2012: Transcatheter therapy, infusion, any method (e.g., thrombolysis other than coronary), RS&I
  - 2013: Transcatheter therapy, infusion, other than for thrombolysis, RS&I
  - Do not report 75896 with 37211–37214
- 37211 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including RS&I, initial treatment day
- 37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including RS&I, initial treatment day

Transcatheter Therapy

- 37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including RS&I, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed
  - 37209/75900 Catheter exchange – DELETED
- 37214 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including RS&I, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method
  - (Report 37211–37214 once per date of treatment)
  - (For declotting by thrombolytic agent of implanted vascular access device or catheter, use 36593)
Transcatheter Therapy

- Coding rules
  - Mechanical thrombectomy & thrombolytics
    - Intraprocedural injection of thrombolytic agent is included w/mechanical thrombectomy
    - Subsequent or prior continuous infusion of a thrombolytic is not included and is separately reported (37211–37214)

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Transcatheter Therapy

- Coding rules
  - 37211 (arterial infusion); 37212 (venous infusion) initial day
    - Bilateral infusion append -50 modifier
    - Includes the following:
      - Follow-up arteriography/venography
      - Catheter positioning change or exchange
      - Fluoroscopic guidance
      - RS&I
  - 37213 (arterial or venous infusion), subsequent day
  - 37214 (arterial or venous infusion), final day
  - Initiation and completion on the same day, report 37211 or 37212 only
  - 37211–37214 include moderate sedation
Transcatheter Therapy

- Coding rules
  - E/M services related to thrombolysis are included
    - Significant, separate services append modifier -25
  - Assign codes for the following as applicable:
    - Catheter placements
    - Diagnostic studies
    - Other percutaneous interventions
    - Ultrasound guidance for vascular access

Transcatheter Therapy

- Coding examples
  - Example #1
    - 11/19/12 Venous thrombolysis initiated at 9 a.m. Thrombolysis check performed at 2 p.m. Treatment discontinued and catheter is removed.
      - 37212
  - Example #2
    - 11/19/12 Arterial thrombolysis initiated at 9 a.m. Thrombolysis check performed at 2 p.m. Treatment discontinued and catheter is removed.
      - 37211
Transcatheter Therapy

- Coding examples
  - Example #3
    - 11/19/12 *Venous* thrombolysis initiated at 4 p.m.
    - 11/20/12 Thrombolysis check performed at 9 a.m. Catheter is exchanged and infusion is continued.
    - 11/20/12 Thrombolysis check performed at 3 p.m. Treatment is continued.
    - 11/21/12 Thrombolysis check performed at 8 a.m. Treatment discontinued and catheter is removed.
      - 37212: 11/19/12, 37213: 11/20/12, 37214: 11/21/12

Transcatheter Therapy

- Coding examples
  - Example #4
    - 11/19/12 *Venous* thrombolysis initiated at 4 p.m.
    - 11/20/12 Thrombolysis check performed at 9 a.m. Catheter is exchanged and infusion is continued.
    - 11/20/12 Thrombolysis check performed at 3 p.m. Treatment is continued. Treatment discontinued and catheter is removed.
      - 37212: 11/19/12, 37214: 11/20/12
Transcatheter Retrieval

- 37203/75961 deleted and replaced with 37197
- 37197 Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g., fractured venous or arterial catheter), includes RS&I, and imaging guidance (ultrasound or fluoroscopy), when performed
  - (For percutaneous retrieval of a vena cava filter, use 37193)
  - Includes moderate sedation

Dialysis Access Maintenance
DAM: Access & Imaging

- **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)
  - Assigned 1 x per encounter; repeat fistulagrams not coded

- **+36148**: Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention
  - Second access required for PTA, stent, thrombectomy, embolization, etc.

DAM: Fistulagram

- **75791**: Angiography, AV shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through the entire venous outflow including the IVC or SVC), radiological supervision and interpretation
  - (For introduction of catheter, if necessary, see 36140, 36215–36217, 36245–36247)
  - (Use 75791 only if radiological evaluation is performed through an already existing access into the shunt or from an access that is not a direct puncture of the shunt)
  - (For radiological evaluation with needle/catheter introduction, AV dialysis shunt, complete procedure, use 36147)
DAM: Selective Catheterization

- If selective catheterization is performed after initial access, code 36147 is dropped and the appropriate selective catheterization code (i.e. 36011 for a venous collateral branch) is assigned.

- When code 36011 is assigned for selective catheterization, code 75791 should be assigned for the fistulagram. Code 36147 is no longer appropriate in these instances.

DAM: Selective Catheterization

- Arterial inflow is considered a separate vessel from the graft
  - If additional catheter work and imaging must be done for evaluation, the work is not included in 36147
  - If the catheter is advanced from the AV shunt puncture into the inflow artery, an additional catheterization code may be reported (36215)
DAM: PTA

- **35476**: Transluminal balloon angioplasty, percutaneous; venous
- **75978**: Transluminal balloon angioplasty venous (e.g., subclavian stenosis), radiological supervision and interpretation
- **35475**: Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
- **75962**: Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or visceral artery, iliac or lower extremity, radiological supervision and interpretation

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DAM: PTA

- Only 1 code pair may be reported for PTA of an AV graft for multiple stenoses:
  - 35475/75962 for an arterial angioplasty
  - 35476/75978 for a venous angioplasty
- *Interventional Radiology Coding User’s Guide* advises that:
  - “All PTA within the arteriovenous dialysis access “vessel” would be coded as a single PTA, regardless of the number of stenoses treated within this segment. For AV dialysis native fistulae, the “vessel” is defined as the inflow artery at the AV anastomosis, the AV anastomosis, and the outflow vein to the level of the axillary vein. For AV dialysis grafts, the “vessel” is defined as the inflow artery at the arterial anastomosis, the arterial anastomosis, the entire length of the graft, the venous anastomosis, and the venous outflow to the level of the axillary vein. All PTA done within these defined segments would be coded as a single angioplasty.”
DAM: Arterial vs. Venous PTA

- PTA of arterial anastomosis only: 35475/75962
- PTA of venous anastomosis only: 35476/75978
- PTA of arterial & PTA of venous anastomosis: 35475/75962
  - Only 1 PTA may be reported for AV graft
  - 35475/75962 column 1 code, 35476/75978 column 2 code NCCI

DAM: PTA

- May code additional PTA for stenosis outside of graft.
- Site of and need for separate stenosis treatment should be clearly documented in the report.
- Example: If PTA of the subclavian vein is performed, codes 35476 and 75978 may be coded for the PTA of the subclavian in addition to the PTA of the graft. The -59 modifier should be appended to the codes for the second PTA.
DAM: Thrombectomy

- **36870**: Thrombectomy, percutaneous, arteriovenous fistula, autogenous or non-autogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)
  - Thrombus may be removed with AngioJet, Amplatz, Trerotola device, Fogarty catheter
  - Includes all work necessary to remove the thrombus, mechanical and/or pharmacological
  - Use of a balloon to remove a thrombus is considered part of the thrombectomy and should not be coded separately
  - Separate stenosis treated by PTA may be coded

DAM: Thrombectomy

- 36870 specifies “includes mechanical thrombus extraction and intra-graft thrombolysis”
  - If a thrombolytic agent is utilized for the same purpose, it should not be coded as a thrombolysis procedure
  - Use of heparin is not considered thrombolysis
  - Thrombus treated outside of graft may assign additional codes for infusion
DAM: Multiple Interventions

- Remember all therapeutic interventions performed in the graft may be coded separately
  - PTA (35476/75978; 35475/75962)*
  - Stent (37205, 75960)
  - Thrombectomy (36870)
  - Embolization (37204, 75894, 75898)

*Note PTA performed to facilitate stent placement may not be coded in addition to stent
*Note only one set of PTA codes may be reported for PTA of graft
*35475 is COLUMN 1 to code 35476

DAM and NCCI

- CPT code 36147 describes introduction of a needle and/or catheter into an arteriovenous shunt created for dialysis (graft/fistula). The code descriptor states that the procedure includes “all necessary imaging for the arterial anastomosis and adjacent artery through entire venous outflow”. Thus, CPT code 76937 (ultrasound guidance for vascular access...) should not be reported separately for ultrasound guidance for insertion of the needle and/or catheter into an arteriovenous shunt. – Chapter 5
Dialysis Access Maintenance

- Puncture into AV graft, fistulagram performed
  - 36147
- Puncture into AV graft, fistulagram performed, (PTA/stent/thrombectomy) requiring second access
  - 36147, 36148

---

Dialysis Access Maintenance

- Puncture into AV graft, fistulagram performed, PTA of venous anastomosis through same access
  - 36147, 35476, 75978
- Puncture into AV graft, fistulagram performed, PTA of venous anastomosis requiring second access
  - 36147, 36148, 35476, 75978
Dialysis Access Maintenance

- Puncture into AV graft, fistulagram performed, PTA of venous anastomosis through same access, followed by PTA of subclavian stenosis
  - 36147, 35476, 75978, 35476-59, 75978-59
- Puncture into AV graft, fistulagram performed, PTA of arterial and venous anastomosis requiring second access, followed by PTA of subclavian stenosis
  - 36147, 36148, 35475, 75962, 35476-59, 75978-59

Dialysis Access Maintenance

- Puncture into AV graft, fistulagram performed, PTA of venous anastomosis and PTA of arterial anastomosis requiring second access
  - 36147, 36148, 35475, 75962
- Puncture into AV graft, fistulagram performed, thrombectomy requiring second access
  - 36147, 36148, 36870
Dialysis Access Maintenance

- Puncture into AV graft, fistulagram performed, followed by selective catheterization of a venous collateral branch, followed by embolization.
  - 36011, 75791, 37204, 75894
- Puncture into AV graft, fistulagram performed, second access required for embolization. Selective catheterization of a venous collateral branch, followed by embolization.
  - 36147, 36011, 37204, 75894

Contact Us

- www.radrx.com
- Stacie L. Buck, RHIA, CCS-P, RCC, CIC
- President & Senior Consultant
- 850 NW Federal Highway, Suite 160, Stuart, FL 34994
- Email: sbuck@radrx.com
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This information is also listed in the instruction email where you found the dial-in information for the program.

Thank you

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Exhibit B

Diagnostic angiography decision tree

Source: Stacie L. Buck, RHIA, CCS-P, RCC, CIC.
This decision tree will assist you in determining whether or not to code diagnostic angiography/venography in addition to a therapeutic intervention.

1. Was a prior catheter based study performed? NO
   YES
   Is it available? NO
     YES
     Was the decision to perform the therapeutic intervention based on the study? NO
       YES
       Has the patient's condition changed with respect to the clinical indication? NO
         YES
         Was there inadequate visualization of anatomy or pathology? NO
           YES
           Was there a clinical change during procedure requiring new evaluation outside of target area of intervention? NO
             YES
             If "NO" to all questions, DO NOT code diagnostic angiography/venography.

           YES
           DO NOT code diagnostic angiography/venography.

       NO
         YES
         Was a full and complete diagnostic study performed immediately before intervention? NO
           YES
           DO NOT code diagnostic angiography/venography.

         YES
         Is diagnostic study performed at the time of the intervention included in the code description for the intervention? NO
           YES
           CODE for diagnostic angiography/venography.

           YES
           DO NOT code diagnostic angiography/venography.
Exhibit C

Required documentation for interventional radiology procedures

Source: Stacie L. Buck, RHIA, CCS-P, RCC, CIC.
Required Documentation for Interventional Radiology Procedures

Catheterizations

1. Clearly document the initial vessel that is the site of access and any additional vessels through which access must be gained. If a second access is required, it is imperative to clearly document the work that was performed via each point of access. For example, if both the left CFA and the right CFA are utilized to gain access for an intervention, the coder must be able to determine the specific work originating from each point of access to ensure that all codes are captured.

2. Clearly document all catheter positions, in particular where the catheter is placed when a contrast injection is performed as this determines the correct radiological supervision and interpretation coding. Also, be sure to mention each branch of a vessel catheterized. Stating “multiple branches” is not sufficient for assigning all applicable catheterization or imaging codes.

Diagnostic Angiography

1. To report any of the diagnostic angiography codes, a complete diagnostic angiogram must be documented in the procedure report. If there is no interpretation for a vessel in which a contrast injection was made, diagnostic angiography may not be reported.

2. It is important to differentiate roadmapping angiography from diagnostic angiography. Any angiography performed for roadmapping purposes (catheter positioning, confirmation of position, guidance, etc.) is not separately reportable. However, if an initial diagnostic angiogram or a medically necessary repeat diagnostic angiogram is performed, the appropriate imaging codes may be reported.

Therapeutic Interventions

1. Diagnostic angiography performed during the same session is coded separately when:
   - there is no prior catheter based study (or computed tomographic study for Medicare);
   - a prior study was inadequate;
   - the patient’s condition has changed since the prior study.

2. Clearly document whether PTA is used to facilitate stent placement or if PTA was a separate intervention. PTA used to deploy a stent or expand the stent after placement is not coded separately, however PTA may be coded with stent placement in the following instances:
   - Initially PTA is utilized for treatment but PTA fails requiring placement of stent
   - PTA is used to treat a complication of stent placement.
   - Two separate lesions are treated in the same vessel, one with PTA and one with stent placement.

Imaging Guidance

1. Clearly document the type of imaging guidance utilized for each procedure to ensure correct reporting of the guidance portion of the procedure as permitted.

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Interventional Radiology Coding, Auditing & Education
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Exhibit D

List of useful industry acronyms

Source: HCPro, Inc.
### HIM Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAPC</td>
<td>American Academy of Professional Coders</td>
</tr>
<tr>
<td>ABN</td>
<td>Advance beneficiary notice</td>
</tr>
<tr>
<td>ACDIS</td>
<td>Association of Clinical Documentation Improvement Specialists</td>
</tr>
<tr>
<td>ADR</td>
<td>Additional documentation request</td>
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<tr>
<td>AHA</td>
<td>American Hospital Association</td>
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<tr>
<td>AHIMA</td>
<td>American Health Information Management Association</td>
</tr>
<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>AOA</td>
<td>American Osteopathic Association</td>
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<tr>
<td>APCs</td>
<td>Ambulatory payment classifications</td>
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<tr>
<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory surgery center</td>
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<tr>
<td>ASP</td>
<td>Average sales price</td>
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<tr>
<td>AWP</td>
<td>Average wholesale price</td>
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<tr>
<td>CAH</td>
<td>Critical access hospital</td>
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<tr>
<td>CC</td>
<td>Complication and comorbidity</td>
</tr>
<tr>
<td>CCHIT</td>
<td>Certification Commission for Health Information Technology</td>
</tr>
<tr>
<td>CCR</td>
<td>Continuity of care record/Cost-to-charge ratio</td>
</tr>
<tr>
<td>CDI</td>
<td>Clinical documentation improvement</td>
</tr>
<tr>
<td>CDM</td>
<td>Charge description master</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
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<td>CPI</td>
<td>Consumer price index</td>
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<tr>
<td>CMI</td>
<td>Case-mix index</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
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<td>CMSA</td>
<td>Consolidated Metropolitan Statistical Area</td>
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<tr>
<td>CPI</td>
<td>Consumer price index</td>
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<td>CPT</td>
<td>Current procedural terminology</td>
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<td>CRNA</td>
<td>Certified registered nurse anesthetist</td>
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<tr>
<td>CT</td>
<td>Computed tomography</td>
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<tr>
<td>CY</td>
<td>Calendar year</td>
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<tr>
<td>DED</td>
<td>Dedicated emergency department</td>
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<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
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<td>DSH</td>
<td>Disproportionate share hospital</td>
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<tr>
<td>ED</td>
<td>Emergency department</td>
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<tr>
<td>EDMS</td>
<td>Electronic Document Management System</td>
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<tr>
<td>EHR</td>
<td>Electronic health records</td>
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<td>E/M</td>
<td>Evaluation and management</td>
</tr>
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<td>EMR</td>
<td>Electronic medical records</td>
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<tr>
<td>EOB</td>
<td>Explanation of benefits</td>
</tr>
<tr>
<td>ePHI</td>
<td>Electronic protected health information</td>
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<tr>
<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
</tr>
<tr>
<td>FFY</td>
<td>Federal fiscal year</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal intermediary</td>
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### HIM Acronyms to Know

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>FY</td>
<td>Fiscal year</td>
</tr>
<tr>
<td>GAF</td>
<td>Geographic adjustment factor</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate medical education</td>
</tr>
<tr>
<td>H&amp;P</td>
<td>History and physical</td>
</tr>
<tr>
<td>HAC</td>
<td>Hospital-acquired condition</td>
</tr>
<tr>
<td>HCCA</td>
<td>Health Care Compliance Association</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HCRIS</td>
<td>Hospital Cost Report Information System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home health agency</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HIC</td>
<td>Health insurance card</td>
</tr>
<tr>
<td>HIMSS</td>
<td>Healthcare Information and Management Systems Society</td>
</tr>
<tr>
<td>HINN</td>
<td>Hospital-Issued Notice of Non-Coverage</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HIS</td>
<td>Health information system/services</td>
</tr>
<tr>
<td>HIT</td>
<td>Healthcare information technology</td>
</tr>
<tr>
<td>HITECH Act</td>
<td>Health Information Technology for Economic and Clinical Health Act</td>
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<td>HMO</td>
<td>Health maintenance organization</td>
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<tr>
<td>HSA</td>
<td>Health savings account</td>
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<td>HSRVcc</td>
<td>Hospital-specific relative value cost center</td>
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<tr>
<td>HQA</td>
<td>Hospital Quality Alliance</td>
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<tr>
<td>HQI</td>
<td>Hospital quality initiative</td>
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<td>ICD-9-CM</td>
<td>International Classification of Diseases, 9th Revision, Clinical Modifications</td>
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<tr>
<td>ICD-10-PCS</td>
<td>International Classification of Diseases, 10th Revision, Procedure Coding System</td>
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<td>ICU</td>
<td>Intensive care unit</td>
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<tr>
<td>IHS</td>
<td>Indian Health Service</td>
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<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>IPF</td>
<td>Inpatient psychiatric facility</td>
</tr>
<tr>
<td>IPPS</td>
<td>Inpatient prospective payment system</td>
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<tr>
<td>IRF</td>
<td>Inpatient rehabilitation facility</td>
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<td>IT</td>
<td>Information technology</td>
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<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
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<td>LCD</td>
<td>Local coverage determination</td>
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<td>LTC-DRG</td>
<td>Long-term care diagnosis-related group</td>
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<td>LTCH</td>
<td>Long-term care hospital</td>
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<td>MAC</td>
<td>Medicare Administrative Contractors</td>
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<tr>
<td>MCC</td>
<td>Major complication and comorbidity</td>
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<td>MCO</td>
<td>Managed care organization</td>
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<tr>
<td>MCV</td>
<td>Major cardiovascular</td>
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<tr>
<td>MDC</td>
<td>Major diagnostic category</td>
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<td>MDH</td>
<td>Medicare dependent hospital (small rural)</td>
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<td>MedPAC</td>
<td>Medicare Payment Advisory Commission</td>
</tr>
<tr>
<td>MedPAR</td>
<td>Medicare Provider Analysis and Review</td>
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### HIM Acronyms to Know

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<tr>
<th>Acronym</th>
<th>Description</th>
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<td>MIC</td>
<td>Medicaid Integrity Contractors</td>
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<tr>
<td>MRHFP</td>
<td>Medicare Rural Hospital Flexibility Program</td>
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<tr>
<td>MS-DRG</td>
<td>Medicare Severity DRG</td>
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<tr>
<td>NAHIT</td>
<td>National Alliance for Health Information Technology</td>
</tr>
<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
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<td>NCD</td>
<td>National coverage determination</td>
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<td>NCHS</td>
<td>National Center for Health Statistics</td>
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<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<td>NCVHS</td>
<td>National Committee on Vital and Health Statistics</td>
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<td>NHIN</td>
<td>National Health Information Network</td>
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<tr>
<td>NICU</td>
<td>Neonatal intensive care unit</td>
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<td>NPI</td>
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<td>NQF</td>
<td>National Quality Forum</td>
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<td>OCE</td>
<td>Outpatient code editor</td>
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<tr>
<td>OCR</td>
<td>Office for Civil Rights</td>
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<tr>
<td>OES</td>
<td>Occupational employment statistics</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<td>OMB</td>
<td>Office of Management and Budget</td>
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<tr>
<td>OPPS</td>
<td>Outpatient prospective payment system</td>
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<tr>
<td>OR</td>
<td>Operating room</td>
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<tr>
<td>OSCAR</td>
<td>Online Survey Certification and Reporting (System)</td>
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<tr>
<td>PHR</td>
<td>Personal health record</td>
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<tr>
<td>PO</td>
<td>By mouth</td>
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<td>POA</td>
<td>Present on admission</td>
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<td>PPI</td>
<td>Producer price index</td>
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<tr>
<td>PPS</td>
<td>Prospective payment system</td>
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<td>Per resident amount</td>
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<td>PRM</td>
<td>Provider Reimbursement Manual</td>
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<td>PRRB</td>
<td>Provider Reimbursement Review Board</td>
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<td>PS&amp;R</td>
<td>Provider Statistical and Reimbursement (System)</td>
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<td>QIO</td>
<td>Quality Improvement Organization</td>
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<td>RA</td>
<td>Remittance advice</td>
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<td>RAC</td>
<td>Recovery Audit Contractor</td>
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<td>RBC</td>
<td>Red blood cell</td>
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<td>RC</td>
<td>Revenue code</td>
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<td>RHC</td>
<td>Rural health clinic</td>
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<tr>
<td>RHIO</td>
<td>Regional health information organization</td>
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<tr>
<td>ROI</td>
<td>Release of information (OR return on investment)</td>
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<tr>
<td>RY</td>
<td>Rate year</td>
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<tr>
<td>SAF</td>
<td>Standard analytic file</td>
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<td>SCH</td>
<td>Sole community hospital</td>
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## HIM Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
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<tr>
<td>SOCs</td>
<td>Standard occupational classifications</td>
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<td>SSA</td>
<td>Social Security Administration</td>
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<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
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<td>ST</td>
<td>Status indicator</td>
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<tr>
<td>TAG</td>
<td>Technical Advisory Group</td>
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<tr>
<td>UHDDS</td>
<td>Uniform Hospital Discharge Data Set</td>
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<tr>
<td>WBC</td>
<td>White blood cell</td>
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<tr>
<td>ZPIC</td>
<td>Zone Program Integrity Contractor</td>
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<td>□ Bill my (✓ one):</td>
<td></td>
</tr>
<tr>
<td>□ Visa</td>
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<td>□ Check enclosed (payable to HCPro)</td>
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<td>□ Bill my facility with PO #</td>
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<th>Account no.</th>
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*(Your credit card bill will reflect a charge to HCPro)*

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