

Coding for Embolization Procedures

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Agenda

- Introduction
- Definitions
- General Coding Guidelines
- Presenting Problems/Medical Necessity for Embolization
- Types of Procedures & Cases
 - Non-Neuro Embolization
 - Radioembolization
 - CNS/Head & Neck Embolization

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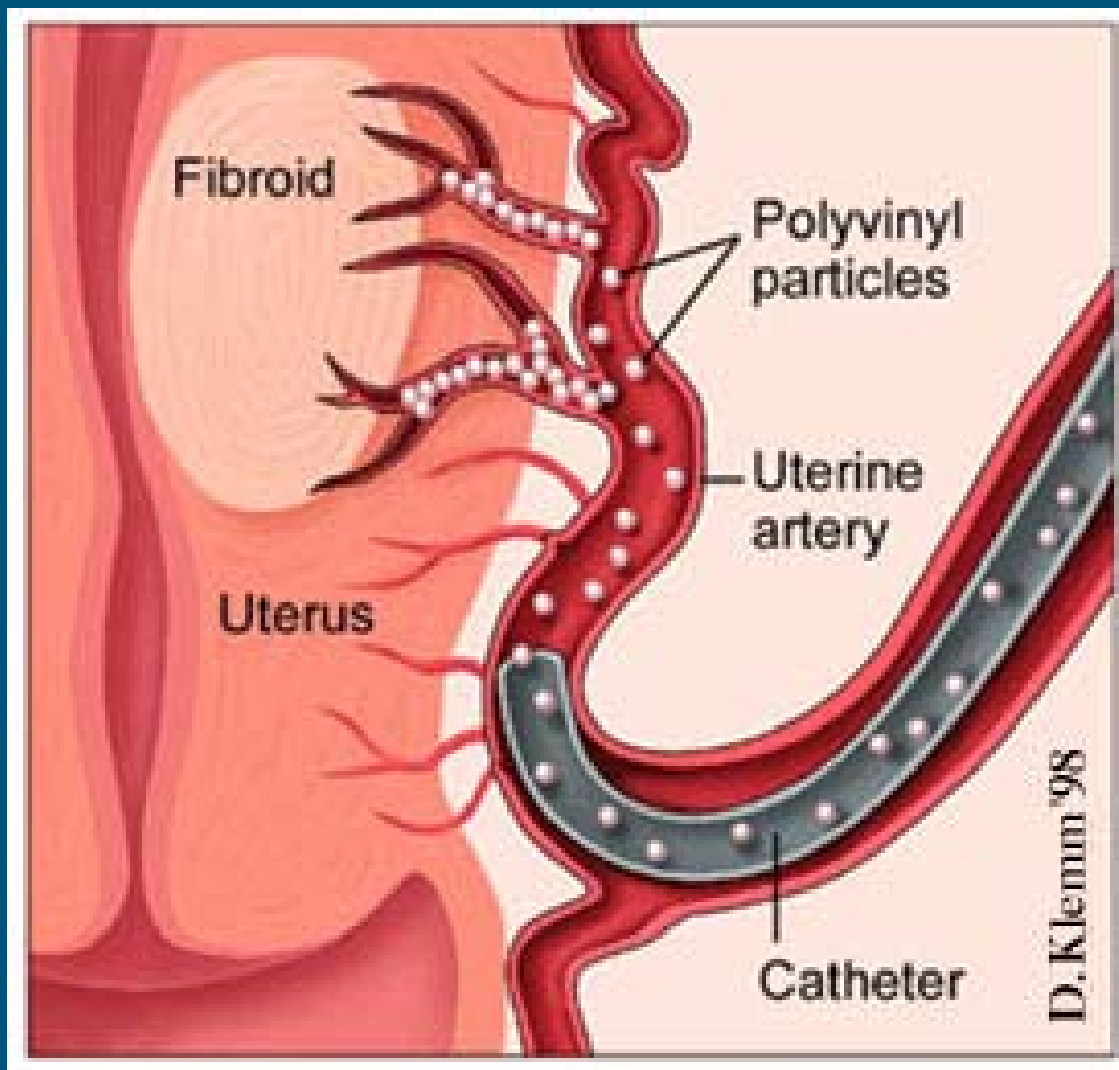
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Resources

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Embolization Procedures

Definition

- Delivery of medications or synthetic materials called embolic agents through a catheter into a blood vessel to block blood flow to an area of the body.
- For control or prevention of abnormal bleeding, to close off vessels supplying blood to a tumor, to eliminate abnormal connections between arteries and veins, or to treat aneurysms.
- Less invasive than open surgery.
- May use glue, coils, microspheres, gelfoam, alcohol, balloons

Embolization-Presenting Problems

- Aneurysm-weakening of an artery wall that creates a bulge, or distention, of the artery
- AVM-abnormal tangle of blood vessels connecting arteries and veins, which disrupts normal blood flow and oxygen circulation.
- Congestion Syndrome
- Hemorrhage-severe bleeding from a blood vessel
- Tumor-mass of tissue that's formed by an accumulation of abnormal cells
- Varicocele-Enlargement of scrotal veins
- Varices-abnormally dilated vessel

Embolization Treatment

37241-Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; **venous**, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

37242-...;**arterial**, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

37243-Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction

37244-Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

General Embolization Coding Guidelines (Non-CNS/Head & Neck)

- Choose code based on the reason for the embolization
- Choose code based on the most immediate medical necessity
- Per surgical field, not per vessel

INCLUDED	SEPARATELY CODED
RS&I	Selective cath placement
Guiding Shots/Roadmapping	Medically necessary diagnostic imaging
Completion Angiogram	Vasc US guidance
Stent to facilitate embolization	Moderate sedation

Case Study #1

EXAM: Inferior vena cavography, left renal venogram, left gonadal venogram and embolization:

HISTORY: Prominent left scrotal varicocele, , ,

FINDINGS: Following written informed consent, patient placed supine on fluoroscopic table with right groin prepared and draped in usual aseptic technique. The skin was prepped using a 2% chlorhexidine-based preparation. Maximal sterile barrier precautions were used during catheter insertion, including the use of a cap, mask, sterile gown, sterile gloves and a large sterile sheet. Proper hand hygiene procedures were utilized. 1% lidocaine used for local anesthetic. Under direct **ultrasound visualization, right common femoral vein was accessed with micropuncture needle. Permanent image was saved to the medical record.** 6-French sheath placed into the right common iliac vein through which a 5-French straight flush **catheter was used to perform inferior venacavography.** Combination of 5-French glide Cobra and regular Cobra **catheter used to select the left renal vein followed by a left gonadal veins with venography** performed. These images demonstrate duplication and stenosis within **paired gonadal veins** with additional collateral veins identified as well. **Catheter was advanced in the medial left gonadal vein** to the level of the anatomical pelvis with placement of 4 3 mm x 5 mm Tornado **embolization coils in the medial and lateral vein.** Next, the **lateral canal vein was accessed with catheter advanced** to the lower left hemipelvis with embolization performed with 4 3 x 5 coils and single 5 x 10 mm Tornado coil. Completion gonadal venography demonstrates near-complete thrombosis of both medial and lateral primary gonadal veins was relatively little flow extending into the anatomical pelvis. Catheters and guidewires removed pressure applied to the puncture site until hemostasis was achieved. Patient tolerated procedure well discharged from radiology department in addition.

MEDICATIONS: Under physician supervision, fentanyl and Versed was administered intravenously for **moderate sedation.** Pulse oximetry, heart rate and blood pressure monitoring was continuously monitored with an independent trained observer present. The physician spent 150 minutes of face to face sedation time with the patient.

GUIDANCE: Fluoroscopic with permanent documentation obtained.

Pain IVC and left renal vein. Left gonadal venography demonstrating to primary canal veins with numerous collateral vessels in the groin, left hemipelvis and left retroperitoneum. Stenosis of the gonadal veins seen near the renal vein. Successful embolization of the medial canal vein with no residual flow on completion venogram. Successful embolization of the lateral gonadal vein with minimal residual flow on completion venogram with little to no retrograde flow in the veins to the level the anatomical pelvis.

Case Study #1 CODES

37241: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

36012X2: Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)

75831: Venography, renal, unilateral, selective, radiological supervision and interpretation

99152: Moderate sedation, initial 15 mins

76937: US guidance for vascular access

Case Study #2

HISTORY: RENAL ARTERY ANGIOGRAM W POSS EMBO. Patient status post medical kidney biopsy on March 31, 2020 who developed sudden left flank pain on April 4. CT demonstrated acute left perinephric hematoma however the patient's vital signs remained stable with minimal drop in the hemoglobin. Over the past 24 hours patient's hemoglobin has slightly dropped and not patient presents for **angiography with possible embolization**.

Comparison: CT abdomen pelvis without contrast April 4, 2020

TECHNIQUE: Patient's **right** groin was prepped and draped in sterile fashion. The skin was anesthetized with 1% lidocaine. Using **ultrasound guidance**, there was puncture right common femoral artery. Hard copy image of the right common femoral artery was record the patient medical record. Next there was advancement of 5 French sheath over a 035 guidewire. Next there was advancement of a 4 French SOS **catheter in left renal artery was selected** followed by angiography. Next there was advancement of an 027 microcatheter over a 014 microwire. The **microcatheter advanced into inferior pole branch** followed by angiography. Next the **catheter was advanced distally into an arcuate vessel** followed by angiography. This **artery vessel was coil embolized using two 2 mm microcoils**. The catheter was withdrawn follow-up imaging was obtained. Next the **catheter advanced into the more inferior arcuate artery** followed by angiography. Next the catheter was removed and follow-up imaging was performed. Next **the catheter advanced to a third arcuate artery** followed by angiography. Next there is arcuate artery was coil embolized using two 2mm coils.

Follow-up imaging was obtained. The catheter was removed. The access site was closed using 5 French Mynx without complication.

FINDINGS: He had angiography left renal artery demonstrates no evidence of renal artery stenosis. The left kidney is displaced superiorly the. There is **evidence of a arteriovenous fistula** within the inferior pole left kidney which corresponds to the site of recent biopsy. There is also a collection of contrast at the inferior pole left kidney **consistent with a pseudoaneurysm**. There is no evidence of acute

Case Study #2

active extravasation. This AV fistula in pseudoaneurysm was confirmed with sub-selective catheterization and angiography. The arteriovenous fistula is fed by an arcuate artery within the inferior pole of the left kidney which was coil embolized. The pseudoaneurysm was fed by two separate arcuate arteries, one of which was embolized during embolization of the AV fistula. The remaining arcuate artery that fills the pseudoaneurysm was catheterized and coil embolized without complication. The final angiogram demonstrates cessation of flow within the AV fistula and pseudoaneurysm. There is no acute complication.

IMPRESSION:

Evidence of AV fistula and pseudoaneurysm involving the inferior pole left kidney which was successfully treated with coil embolization without acute complication.

Contrast used: 70 cc Isovue 370.

Total Fluoroscopic time: 22.2 minutes

Number fluoroscopic image obtained: 405.

Moderate sedation was administered under the radiologist supervision.

The patient received Versed 1.0 mg and Fentanyl 100 micrograms intravenously. A certified registered nurse independently monitored the patient including continuous oxygen pulse oximetry, heart rate and blood pressure and documented the sedation throughout the procedure. The operating physician and/pr physician assistant was within the room with the patient for 90 minutes of moderate sedation time.

Case Study #2 CODES

37242: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

36253: Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

76937: US guidance for vascular access

99152: Moderate sedation, initial 15 mins

Case Study #3

Bilateral uterine artery embolization.:

PRE-PROCEDURE DIAGNOSIS:

Large symptomatic **known** uterine leiomyoma previous identified

POST-PROCEDURE DIAGNOSIS:

Same, s/p bilateral uterine artery embolization.

CONSENT: The risks, benefits, and alternatives of the planned procedure were explained in detail to the patient. Questions were answered and written informed consent was obtained.

STERILE PREPARATION:

All elements of maximal sterile barrier technique were followed, including use of cap, mask, sterile gown, gloves, sterile sheet, chlorhexidine 2% isopropyl alcohol, and appropriate hand hygiene.

SEDATION:

This procedure was performed with an anesthesiologist who monitored and anesthetized the patient.

DESCRIPTION OF PROCEDURE AND FINDINGS: The patient was placed supine on the angiography table and the **bilateral groins** were prepped and draped in usual standard fashion. After infiltration of 1% lidocaine anesthesia, the right common femoral artery was entered using single wall technique under direct ultrasound visual guidance (image stored). A J-wire was advanced to level of the diaphragm and the needle was exchanged for a 5 French sheath. A 5 French Omni Flush **catheter was advanced to the distal abdominal aorta and aortography** was performed. With the assistance of a Bentson wire, the Ominflush catheter was exchanged for a 5F C2 Cobra catheter over the bifurcation. The C2 was used **to select the left internal iliac artery** and angiography was performed. The C2 catheter had difficult time engaging the uterine artery and was exchanged for a Roberts uterine catheter. Using a Progreat microcatheter and microwire, **the left uterine artery was selected** and angiography was performed. 300 ug of IA nitro was administered prior to embolization.

Case Study #3 (Cont'd)

Using 1 vial of 500-700um 1 vial of 300-500um embospheres, the **left uterine artery was embolized** to near stasis. Post-embolization angiography was performed. The RUC was used to **select the right internal iliac artery** and angiography was performed. The RUC was used to select the right internal iliac artery and angiography was performed. Using a Progreat microcatheter and, **the right uterine artery was selected** and angiography was performed distal to cervicovaginal branches. Using 2 vials of 500-700um embospheres embospheres, the right uterine artery was embolized to near stasis. Post-embolization angiography was then performed.

Limited right femoral angiography was performed to evaluate the puncture site. Hemostasis was achieved with manual compression. The patient tolerated the procedure well without complication.

FINDINGS: - The right common femoral artery is patent by ultrasound.

- The lower abdominal aorta is patent. The bilateral common iliac, external iliac, and internal iliac arteries are patent.
- The bilateral uterine arteries are enlarged and the large central fibroid is visualized. No evidence of arteriovenous shunting.
- Post embolization, the uterine arteries demonstrate near stasis of flow.
- The right common femoral artery is patent by angiography and hemostasis achieved with manual compression.

PLAN:

- Overnight observation for pain control with plan for discharge tomorrow.
- F/u in IR clinic in approximately 3 months to evaluate for an improvement in symptoms. F/u phone call next week to assess for any post-procedural issues and appropriate recovery from procedure.

IMPRESSION: Status post bilateral uterine artery embolization, as above.

Case Study #3-CODES

37243: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction

36247-50: Selective catheter placement, arterial system; initial 3rd order or more selective , pelvic, or lower extremity artery branch

76937: US guidance for vascular access

Case Study #4

Reason for Exam: GI BLEED

Procedure:

1. Abdominal Aortogram.
2. Celiac catheterization and angiogram (1st order branch).
3. Superior mesenteric artery catheterization and angiogram (1st order branch).
4. Common hepatic artery catheterization and angiogram (2nd order branch).
5. Gastroduodenal artery catheterization and angiogram (3rd order branch).
6. Anterior superior pancreaticoduodenal artery catheterization and angiogram (4th order branch).
7. Gastroduodenal artery embolization (3rd order branch) and post embolization angiogram.

Diagnosis/REASON FOR EXAM: **Active upper GI bleed**. Recent endoscopy demonstrates active bleeding in the duodenum. CTA demonstrates active contrast extravasation into the second portion of the duodenum

Additional: History: 2.5mg versed 100mcg fentanyl start 2140 stop 2325 Upper gastrointestinal bleeding.. Endoscopic bleeding from duodenum.

Contrast: 160 cc's visipaque cc ia Complications: None Estimated blood loss: less than 5 cc
Conscious Sedation: 2.5 mg of Versed IV, 100 mcg of fentanyl IV.

Physician **Face-to-face sedation time: 105 minutes**. Patient was re-assessed prior to sedation. Under physician supervision, intravenous moderate sedation was administered. Pulse oximetry, heart rate, blood pressure, and vital signs were continuously monitored by an independent trained observer present.

Case Study #4 (Cont'd)

Fluoroscopy time: 35 minutes. Number of fluoroscopic images: 30+ .

Technique: Discussed with Dr. A of the hospitalist service prior to the case. Endoscopy demonstrates bleeding from duodenum. **CTA demonstrates extravasation** from the duodenum. Angiogram and embolization of any bleeding source or empiric embolization of the GDA requested. Time out performed including verification of patient, date of birth, procedure and sidedness as appropriate. Informed written consent was obtained from power of attorney the daughter. Patient is confused. Sterile technique and lidocaine for local anesthesia.

1. Using a 21-gauge micropuncture set, a retrograde **right** common femoral artery 5-French sheath was placed. Continued motion artifact throughout the case as the patient could not lie still or suspend respirations which made the procedure and imaging difficult.
2. Marker flush **catheter into the abdominal aorta** for abdominal arteriogram.
3. **Celiac artery catheterization and angiogram** (1st order branch). 5fr Mickelson catheter.
4. **Common hepatic artery catheterization and angiogram** (2nd order branch). Coaxial microcatheter.
5. **Gastroduodenal artery catheterization and angiogram** (3rd order branch). Coaxial microcatheter.
6. **Anterior superior pancreaticoduodenal artery catheterization and angiogram** (4th order branch). Coaxial microcatheter.
7. **Gastroduodenal artery embolization (3rd order branch)** and post embolization angiogram. No active extravasation seen initially. As per the initial plan, prophylactic embolization of the gastroduodenal artery was undertaken. Through the microcatheter which was advanced into the proximal anterior superior pancreaticoduodenal artery for adequate purchase, coil embolization of the gastroduodenal artery was undertaken. Note that during embolization of the GDA, while injecting the partly embolized GDA, a small branch pointed toward the right off the proximal GDA was seen that gave rise to a region of active extravasation in the region of the second portion of the duodenum. This small branch could not be selectively catheterized due to angle of anatomy. Additional coils in the GDA were then extended proximally to cover the origin of this branch. The following interlock and Concerto detachable coils were utilized: 3 x 60 mm and 2 x 40 mm interlock, 3 x 80 mm Concerto x2, interlock coils as follows: 3 x 60, 4 x 80, 3 x 60 x 2, 4 x 80 x 2, then 3-D Concerto coils: 5 mm x 150 mm, 4 mm x 100mm. Coils extend from the anterior superior pancreaticoduodenal artery up through the proximal GDA across the origin of the side branch that supplied the active extravasation. Post embolization angiogram via GDA injection.

Case Study #4 (Cont'd)

8. **Superior mesenteric angiogram (1st order branch).** Mickelson catheter. . Injected to assess for collateral supply to site of embolization. .

9. Sheath removed. Hemostasis with manual compression.

Findings: Aortogram demonstrates patent celiac, SMA, renal arteries, in ap projection. Celiac, common hepatic, gastroduodenal, and right gastroepiploic angiograms demonstrate these vessels are patent. Initially no extravasation is seen. During coil embolization of the GDA, while injecting the partly embolized GDA, a small branch pointed toward the right off the proximal GDA was opacified and gave rise to a region of active extravasation in the region of the second portion of the duodenum.

After embolization of the GDA with coils extending across the bleeding side branch , complete stasis of the GDA with no filling of the bleeding side branch. SMA angiogram demonstrates patent sma without extravasation or collateral supply to the GDA/embolized region. SMV and portal vein patent.

IMPRESSION:

1. Extravasation from small side branch off the proximal GDA.
2. Successful coil embolization of GDA to complete stasis.

Case Study #4-CODES

37244: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation; for arterial or venous hemorrhage or lymphatic extravasation

36247: Selective catheter placement, arterial system; initial 3rd order or more selective , pelvic, or lower extremity artery branch

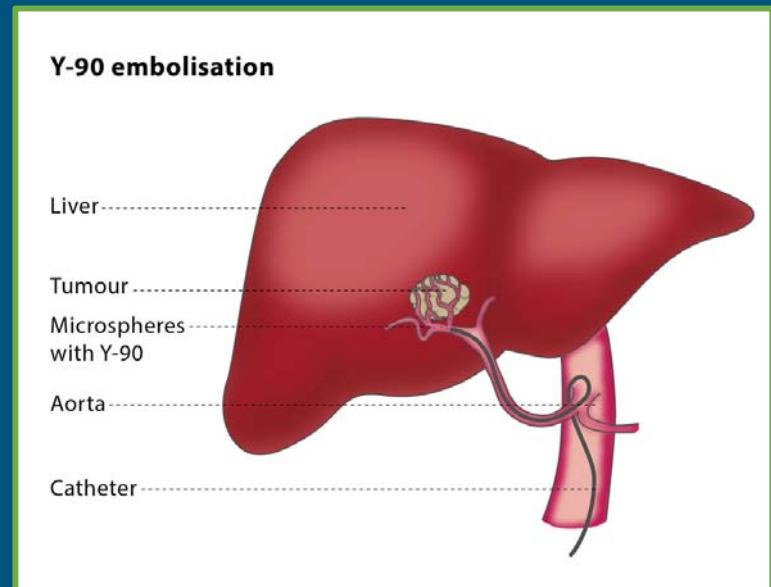
36245: Selective catheter placement, arterial system; each 1st order or more selective , pelvic, or lower extremity artery branch

99152: Moderate sedation, initial 15 mins

Radioembolization

Radioembolization (Y90)

- Planning Arteriogram
- Prophylactic Embolization of Non-Target Vessel
 - Prior Session-37242
 - Same Session- *Not separately billable*
- Nuclear Medicine (MAA) Injection- *Not billable*
- Treatment Delivery
 - Radioisotope Injection (79445)
- Authorized Users
 - Dosimetry
 - Treatment Planning



Embolization-CNS/Head and Neck

- 61624-Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; **central nervous system (intracranial, spinal cord)**
- 61626-Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; **non-central nervous system, head or neck (extracranial, brachiocephalic branch)**
- 75894-Transcatheter therapy, embolization, any method, radiological supervision and interpretation

Embolization-CNS/Head and Neck

- Transcatheter Procedures
- Completion Angiography
 - CNS vs. Head/Neck
 - MUE=2

INCLUDED	SEPARATELY CODED
Guiding Shots/Roadmapping	Selective cath placement
Stent inclusive of angioplasty	RS&I
Closure Device (stent)	Completion Angiography*
	Vasc US guidance
	Moderate sedation

Case Study #5

PROCEDURE: IR EMBOLIZATION NEURO

INDICATIONS: **S06.5X9A. Traumatic subdural hemorrhage** with loss of consciousness of unspecified duration, initial encounter (HCC),

TECHNIQUE: The patient was informed of the risks, benefits, and alternatives of the offered treatment. The patient expressed a desire to proceed.

A **prior catheter-based angiographic/venographic study is not available**. A full diagnostic study is now performed.

ACCESS SITE: Right common femoral artery

VESSELS SELECTED: Aortic arch, left common carotid artery, left internal carotid artery, left external carotid artery, and left middle meningeal artery

CONTRAST WAS INJECTED IN THE FOLLOWING VESSELS: Aortic arch, left common carotid artery, left internal carotid artery, left external carotid artery, and left middle meningeal artery

INTERVENTION: Based on the findings of the diagnostic study, we decided to proceed with the following intervention:

Embolization of the left middle meningeal artery

FLUORO TIME: 29.1 minutes NUMBER OF IMAGES: 192 images

SEDATION: General endotracheal anesthesia.

FINDINGS: Aortic arch injection: There is plaque formation at the origin of the brachiocephalic arteries, without hemodynamically significant stenosis.

Left external carotid artery injection: External carotid artery branches are identified, including the middle meningeal artery.

Vasospasm noted, treated with intra-arterial injection of 2.5 mg of verapamil. A repeat contrast injection after 5 minutes into the left external carotid artery reveals resolution of vasospasm.

Case Study #5 (Cont'd)

Left middle meningeal artery injection: Contrast injected into the left middle meningeal artery reveals the dural branches.

Left middle meningeal artery embolization: Utilizing 300-500 micron PVA particles, under fluoroscopic guidance, significant decrease in flow to the left middle meningeal artery identified, with multiple injections of contrast. Then, 2 platinum Axium microcoils (1.5 mg x 2 cm, 1.5 mg x 3 cm) were utilized to embolize the base of the dural branches of the middle meningeal artery.

Repeat left middle meningeal artery arteriogram: There is near complete obliteration of the dural branches of the left middle meningeal artery, after embolization.

Left common carotid artery injection: Patency noted with slight plaque formation. No embolism or hemodynamically significant stenosis.

Left internal carotid artery arteriogram: There is normal filling of the left internal carotid, anterior, middle, and also posterior cerebral arteries, except for medial shift of the distal MCA branches due to the subdural hematoma. No thromboembolism, large vessel occlusion, aneurysm, or vascular malformation.

CONCLUSION: Technically successful fluoroscopically guided left middle meningeal artery embolization for recurrent left frontoparietal convexity subdural hematoma. No immediate postprocedure complication.

Case Study #5-CODES

- 61624: Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)
- 36224: Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed
- 36227: Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
- 75894: Transcatheter therapy, embolization, any method, radiological supervision and interpretation
- 75898: Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis

Case Study #6

Procedure Note:

HISTORY: Persistent **nasal bleeding** not responsive to nasal packing conservative therapy

STUDY: Left common carotid arteriogram, left external carotid arteriogram and left internal maxillary catheterization, arteriography and embolization with coils.

Fluoroscopy time 11.3 minutes.

Contrast utilization 55 mL Omnipaque 300

Procedure description: Initial access performed from the **right** common femoral arterial approach and 6 French sheath advanced to the aortic arch. **Catheterization of the left common carotid artery was then performed and arteriography** demonstrates normal carotid bifurcation. **Left external carotid slightly catheterized** and identification of the left internal maxillary artery performed. Catheterization then performed with a 5 French **catheter at the proximal left internal maxillary artery** and confirmation of the vascular anatomy. 3 French microcatheter was then introduced via the 5 French catheter and the catheter was advanced beyond the origin of the middle meningeal artery. Coil **embolization of the distal internal maxillary artery** then performed with cessation of blood flow. Microcoil embolization with 3 mm and 4 mm 0.018 microcoils. At the end of procedure the catheters were removed and hemostasis obtained at the right groin.

1. Common carotid arteriography demonstrates normal left carotid vascular anatomy and the external carotid arteriogram demonstrates the internal maxillary artery.
2. Left internal maxillary artery arteriogram demonstrates the nasal branches and coil embolization just proximal to the bifurcation of the greater palatine and sphenopalatine branches then performed. Microcoil embolization with 2, 3 mm coils and a 4 mm coil.

Case Study #6-CODES

61626: Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)

36222: Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

36227: Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

75894: Transcatheter therapy, embolization, any method, radiological supervision and interpretation

Q&A



Thank you!

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