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Cpt code for ct guided pelvic abscess drainage placement

By Coding Strategies on January 30th, 2015 We are frequently asked to review documentation to determine if the service performed was an aspiration or drainage procedure. Confusion seems to have grown with the revision of the CPT® drainage codes in 2014, so let's take a few minutes to review the guidance regarding reporting these codes and a few of the most common codes available for aspiration and drainage procedures. In the Summer 2014 Issue of Clinical Examples in Radiology, the ACR/AMA stated that: The correct code depends on whether an "aspiration" or "drainage" is performed, these are distinguished by whether or not a drainage catheter is left in place at the conclusion of the procedure ("drainage") or whether the fluid collection is aspirated with a needle or catheter that is removed at the conclusion of the procedure. In addition to the Clinical Examples in Radiology article, Diane Hayek, the Director of Economics & Health Policy for the ACR stated in an email to the RBMA Coding Forum: The intent of the new CPT drainage codes was that a catheter was to be left in for longer term drainage, not just for aspiration. Placement of a catheter that is used to drain the fluid and then is immediately removed does not meet the criteria for any of the new drainage codes. Now that we have that settled, let's review the most common aspiration and drainage codes. Aspiration Procedures: Percutaneous aspiration is the evacuation of fluid through a needle or catheter for diagnostic or therapeutic purpose where the needle or catheter is removed at the end of the procedure. With the code revisions for 2014, several of the existing aspiration codes were deleted. Now we have only a few site specific aspiration codes and one code that should be used to report any aspiration without a site specific code. The following is a table of the most common aspiration codes. Code Description 10160 Puncture aspiration of abscess, hematoma, bulla, or cyst 19000 +19001 Puncture aspiration of cyst of breast each additional cyst 32555 Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance 49083 Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance 50390 Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous 60300 Aspiration and/or injection of thyroid cyst Codes 19000/19001 should only be used when a breast cyst is being aspirated. If an aspiration is being performed on another type of fluid collection in the breast (e.g., seroma) then the appropriate code to report is 10160. Only the thoracentesis and paracentesis include image guidance. The appropriate image guidance code should be assigned with 10160, 19000/19001, 50390, and 60300. Drainage Procedures: As with the aspiration codes in 2014, the several existing drainage codes were deleted and replaced new codes. No longer do you have to determine if the drainage procedure is for a peritoneal, subdiaphragmatic or retroperitoneal abscess. Another change with the new codes is that imaging guidance is no longer separately billable. Below is a table of the most common drainage codes. Code Description 10030 Image guided fluid collection drainage by catheter (e.g., abscess, hematoma, seroma, lymphocele, cyst) soft tissue (e.g., extremity, abdominal wall, neck), percutaneous 32557 Pleural drainage, percutaneous with insertion of indwelling catheter, with imaging guidance 49405 Image guided fluid collection drainage by catheter (e.g., abscess, hematoma, seroma, lymphocele, cyst) visceral (e.g., kidney, liver, spleen, lung/mediastinum), percutaneous 49406 Image guided fluid collection drainage by catheter (e.g., abscess, hematoma, seroma, lymphocele, cyst) peritoneal or retroperitoneal, percutaneous Notes in the CPT® manual state that a drainage code should be assigned for "each individual collection drained with a separate catheter." Code 10030 is used for drainage of fluid collection in any part of the body – for example, abdominal wall, soft tissue of the neck, or breast seroma. Code 49405 should be used to report catheter drainage of a pancreatic pseudocyst or a renal abscess. Code 49406 should be used to report a psoas muscle catheter drainage according to Clinical Examples in Radiology, Fall 2103. In a study of CT-guided percutaneous catheter drainage for acute necrotizing pancreatitis, Mortelé et al found that primary CT-guided percutaneous drainage was successful in approximately 50% of patients. [6] The presence of multisystem organ failure appeared to be a more important indicator of outcome than the presence of infection. In all, 17 of the 35 patients in this study were treated successfully with CT-guided percutaneous catheter drainage alone. [6] The effectiveness of this approach in patients with sterile necrosis was not significantly different from that in patients with infected necrosis. Of 11 patients with multisystem organ failure (10 with sterile necrosis, one with infected necrosis), only four were treated successfully with CT-guided drainage alone; five patients died. Of 24 patients without multisystem organ failure, 13 were treated successfully with CT-guided percutaneous drainage alone; one patient died. According to Weber et al in a German study, percutaneous transhepatic biliary drainage (PTBD) should be considered the treatment of choice in patients with benign anastomotic stricture after bilioenterostomy, especially after stricturing of a hepatojejunostomy. [7] Between 1996 and 2006, the authors studied 44 patients with benign anastomotic stricture after bilioenterostomy, and in 27 of the patients (successful treatment, 61.4%), the percutaneous transhepatic biliary drain was successfully removed after 19.9 ± 16.1 months. [7] During follow-up (mean, 53.7 ± 28.4 months after removal of the drain), there was no evidence of recurrent strictures. Permanent drains were necessary in 10 of the 44 patients. In seven of the 44, repeat operation was necessary because of PTBD failure. Kloek et al compared the outcomes of endoscopic biliary drainage (EBD) and PTBD in 101 patients with resectable hilar cholangiocarcinoma (HCCA) between 2001 and July 2008, 90 of whom underwent EBD and 11 PTBD. [8] The technical success rates were 81% for EBD and 100% for PTBD. Stent dislocation was similar in the EBD and PTBD groups; infectious complications were significantly more common in the EBD group; and patients in the EBD group underwent more drainage procedures and had a significantly longer drainage period until laparotomy. In 30 patients, EBD was converted to PTBD because of EBD failure. Yamakado et al evaluated the safety, feasibility, and clinical utility of percutaneous transhepatic drainage under real-time CT guidance in 12 patients with inaccessible abdominal abscesses. [9, 10] (Abscesses were considered inaccessible because they were surrounded by the liver and other organs.) In this study, an 8-French catheter was advanced into the abscess cavity through the liver parenchyma. Drainage catheters were placed with no complications in all patients, and all abscesses were drained, shrinking immediately after catheter placement. Pugmire et al assessed the success rate of PAD for abscesses related to Crohn disease in 25 pediatric patients, paying particular attention to end points relevant to biologic therapy. [11] Success was classified as either technical (ie, catheter placement within the abscess with reduction in abscess size on posttreatment imaging) or clinical (either no surgery within 1 year of drainage or surgical resection following drainage with no residual abscess at surgery or on preoperative imaging). All cases were classified as technical successes, and 19 were considered clinical successes. Ye et al, in a study comparing the outcomes of posterior and anteroposterior approaches to percutaneous drainage of tubercular psoas abscesses, found that the posterior approach appeared to have the same clinical efficacy as the anteroposterior approach but was associated with a shorter average hospital stay and a lower complication rate. [12] cpt code for ct guided drain placement

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