Digital subtraction angiography cpt

77 Item(s) Screen 5 10 15 20 25 40 100 rt common femoral artery is punctured and becomes selective celiac angiography and lt hepatic medial division angiography. a radio involbolisation is carried out and the catheter is removed. same access point new catheter, lt hepatic lateral division catheterization and selctive angiography is performed and radioembolization performed. I code 36247, 75726, 75774 for the 1st case. 2nd catheter must encode as 36247-59 & 75726-59 or 36248 & 75774; thank you for writing to ask for an explanation for the answer given to a test question in the basic catheter selection module exam. The question was exactly as stated: Correct code(s) for left femoral catheter access placed on the right surface artery for angiolineal is (is: 36247, 36246, 36245 36247, 36200 36247 36247, 36140 The correct answer was indicated as 36247. , but I assumed it was the boat in question); if so, the access was on the left and the Lower Edge Arterial Anatomy Diagram Right Transfemoral Approach leads me to 36245 for the right foot in this diagram. 36247 is the code for the left foot. I think the left approach starts me on the wrong chart and I have to choose the code based on the Order of the ship selected (3rd row, initial, lower end) and the fact that it is a selective (placed) probe. Please explain how to use the diagram to simplify the basic catheter option. Thanks a lot for your extremely useful webinars, but I want to make sure I have the basics down pat now. Doctor chose section VI and section VII of the posterior division of the right hepatic artery. How do you encode it? Is it just 36247? Or is it 36247, 36248, 36248? Our supplier selectively catheters the left superficial femoral artery from a right femoral approach. Pulling back from there catheterly the left subgastic artery. Should it be 36247 and 36246? Or 36247 and 36248? When the procedure is ordered for the treatment of DR, and from the femoral artery the catheter is selectively placed in the internal iliac in the pudendal and then finally in the artery of the penis where angioplasty is performed, should codes 37246 and 36247 be indicated? Or should codes 37788 and 36247 be mentioned? Then how about atherosclerosis was the reason for the A.N. and was treated with angioplasty ... would it be the code then 37220? I'm completely confused about abdominal aortic imaging. Does code 75625 require two catheter placements or not? For example: The doctor places a catheter in the abdominal aorta near the renal and performs abdominal aorography. also documents bilateral pelvic imaging together with common femurs. Then the catheter in the SFA and completes the angiography with chase bolus run-off on the leg on the left. Is it encoded as 36247, 75625, 75716? Or is it 36247, 75630? You can confirm the catheter placement codes case of samples? Contralateral approach: A catheter was used to select the origin of the left femur-popliteal arterial bypass graft. The catheter and wire were propelled through the thrombomenic graft (36247) into the proximal popliteal artery (36247 or 36248??). The catheter was then used to select the anterior tibia, posterior tibia, and peronal arteries (36248 x 3???). I hope you can clarify something for me. With the new UFE procedure code, code 36247-50 is recommended when running bilaterally. I can understand the opposite artery of the uterus is a third row, but the ipsial artery of the uterus appears to be second class (common femoral puncture - 36140, internal iliacs - 36245, uterine artery - 36246). Am I thinking completely wrong? I have a case was a chemoembolization carried out in the liver arteries and an angioplasty was performed on the left outer iliac artery. The pottery wasn't planned; stenosis was found when trying to cannulize the artery for embolism. The problem is that I have to use codes 37243 and 37220 for two different vascular families, and due to the fact that a diagnostic angiography was performed on the outer iliac I have catheter placements for both areas of treatment, so codes 36247 and 36248 x 3 for liver embolism and 36249 for the diagnostic angiographer in the external ililic. Because of code 37220, codes 36247 and 36246 both require a -59 modifier, but code 36247 overrides 36246. How do we deal with this so that both catheter placements are paid for? I'm right assuming that if a patient has a liver chemobolism, say 75726, 75774, 36247, 37243 was originally charged. Now the patient returns for a repeat chemoembolization a month or so later, maybe a few months... for the return visit, would it be right to bill just 37243/36247 unless the diagnostic imaging was done for a different purpose? You're not re-billing the diagnostic imaging, are you? I have a case where the left liver comes directly from the aorta and not the celiac disease. They chose the right hepatic and left hepatic, and then, through the Chung catheter, a microcatheter was used to select the section 4B branch of the left hepatic artery that provides the tumor. Chemoembolization was then carried out of this artery. I can't find a diagram showing the catheter option for the anatomy variant of the liver. I have a 36247 for the right liver option, but I'm not sure if 4B is a 36246 or 36247. I can't find any reports of this question in your drivers. Left femoral artery was accessed and above and above technique used to place the catheter in the right SFA. The angiogram's over. The catheter then promoted to peripheral popliteal and a second angiogram is performed. The catheter has been removed. Then the right femoral artery was punctured and a catheter was advanced in two branches the peripheral AT for angiography followed by embolism of an AVM. I can use codes 36247/36247-59 for third-class catheter placements from two access to sites? Could you please specify the appropriate encoding of catheter placements in the liver arteries from the celiac artery? What we see most often is that the doctor will place the catheter in the common liver (36246), but after that, we have conflicting coding information. If the catheter is placed in the appropriate hepatic, left hepatic, and right hepatic, is it correct to report with codes 36247 and 36248 x 2, since these are all third-class vessels? Or is the correct and correct liver considered a coded container for some reason, and if the catheter is placed in both of them, is it referred to only by code 36247? Also, where does the average liver come into play? I often see this artery mentioned, but it is not listed in any reference book I have. I don't understand how to report catheterization of multiple sectional arteries of the left hepatic artery. Here is an example ... The patient has HCC and presents for embolism. The OP report states: Catheterization and arteriogram of the LHA segment and additional segmental branch. Also catheterization and arteriogram of the segmental branch of the compensated RHA. The embolism of both arteries took place then. Dr.'s doing an arteriogram, trying a percutaneous thrombectomy that didn't solve the problem. He then does an open thrombectomy of a femur-anterio tibia bypass. When doing an arteriogram he discovers a pseudonaneurysm of the anterior tibia over anastomosis. Then angioplasty and stent the pseudoanyronym that corrects the problem. Since we now have the new endovascular codes are not going to use for pseudoanyurysm correct? How would we code that? The doctor used 36247 75710 75774 37230 and 34201. I know this is not correct according to his note the clot was not beyond anastomosis. I want to encode 36247 75710 75774 and 35875, but I do not know how to encode the treatment pseudoanyursm. Thank you, The following SIR-Sphere procedure was mentioned with codes 37243, 36247 and 36245. Should a modifier -59 be added to codes 36247 and 36245? PROCEDURES EXECUTED: 1) Coeliac arteriogram. 2) Upper mesenteric arteriogram. 3) Selection of the replaced auxiliary hepatic artery with arteriogram. 4) Yttrium-90 SIR-Spheres radio-intbolization delivered via the replaced auxiliary right hepatic artery with IR function in conjunction with the authorized user overseeing the procedure. 5) After embolization arteriogram of the replaced accessory right hepatic artery. 6) Fluoroscopic guidance for the above. How do you encode catheterization in this case? Left radial access gained. The left anterior division of the inner iliac Multiple attempts were made to gain access to the left prostatic artery, including Sniper microcatheter and Fathom microwire; However, the left prostatic artery was not canned or vaccinated at this time. Then the right anterior division of the inner iliac was canned. The prostatic artery artery sub-selected canned. The balloon in the Sniper microcath catheter was inflated, and the right prostatic artery embolism was performed in a stop with 300-500 microparticles of Will this case be reported with codes 36247 and 36248? Or 36246 and 36247? ... style=background color:#fff08c;. >36247,35475, 75978 (angioplasty for the arterial side of the fistula) and 36247 59,7507859 (angioplasty of the brachial artery); The radiologist refuses to say maternal brachial artery. It also doesn't say how far over the anastomosis. I was checked a few weeks ago and now I'm second guessing myself (I work for the hospital). I have your coding book, and I love it. Thanks. Frances () AVS PROCEDURE (FISTULAGRAM) - Indications: Poor blood flow during dialysis and pulling clots. RESULTS: ARTERIAL VENOUS FISTULA: Technique: Informed consent was obtained from the patient. Access was also gained to the arterial venous side of the patient's arterial venous fistula. Then the contrast is intensified. Angioplasty followed on the arterial side of the fistula with a 5 mm balloon. Hemostasis has been acquired. Complications: No immediate complications occurred. Medications: 1% topical lidocaine in the skin, Experienced and Fentanyl for conscious sedation. Approach: X-ray. Fitness: ASA-4 Findings: The patient displays a brachio-royal fistula. There is stenosis that includes the arterial side of the fistula in the range of 80% to 90% with some mild aneurysm formation. This was successfully treated with angioplasty with improved passability. There was an area of irregularity involving the brachial artery above anastomosis which was angioplasty. This was resolved after that. There is an indwelling stent that includes the venous outflow structure. Only some minimal stenosis in it was detected, but this was not addressed because this was in the range of 20% to 30%. There is also an indwelling stent inside the right brachiocephalic vein in the upper concave vein. That looks patented. INVESTMENT: Successful arterial venous stygidonium with arterial lateral angioplasty and brachial artery angioplasty for abnormalities. Can codes 36245-36247 be charged when performing a diagnostic angiography for a lower extremity examination on the same intervention day if there is no previous visualization (or if the situation has changed since the previous visualization)? I have a Y-90 delivered to section 2 and 3 of the left hepatic artery. Charge asks for 36247 and 36248 removed because embolism states that includes all the 'mapping' and it appeared from the notes that they were finding their way to site to enter brachytherapy. Can you please update? Dear Dr. Z Good evening I am your student through webinars. I was able to encode most of the charts confidently after listening to your webinars. But then there's the case where I feel a little chalenge. Please Please Patient doesâ? Tt have any previous catheter based on angiogram of the lower extremities. Now, the patient with peripheral vascular disease. Scheduled angiogram to evaluate lower limb PVD and intervention as required for the limb rescue process. Right faria arterial placement sheath and right common faria angiography done. Subsequently, adobiomilic angiography was performed. Follow this left common femur and popliteal angiography with runoff done. Then the cable was on the dissection plane. Then, an ultrasound re-entry device was used to re-enter the peripheral SFA. Then, TurboHawk Atherectomy and angioplasty is performed on a superficial femoral artery. After this atherectomy of the tbioporoneal trunk was done. My Coding 36247-59, 75625-59, 75716-59, 76937-59, 37225 & 37229 Q) 1) As a patient doesn't? Tt have the previous catheter based angiogram, encoded 36247-59 for Angiogram (based on this angiogram only doctor decided to make intervention). Am I right? Q) 2) Is 76937 (ultrasonic guidance for re-entry) appropriate here? I appreciate your help bilateral uterine fibroids embolism with catheter placements in both uterine arteries and selective right/left internal iliac artery angiography. We should now be able to name codes 36247 and 75736 to 37243, right? No longer including like code 37210? When the doctor chooses the correct hepatic artery for tumor embolism we will no longer mention code 36247, right? Because the new embolization code 37243 includes the selection codes now? Will this be codified as delayed graft extension 33886/75959/36247, or 37236/36247 for doctor IR? History of thoracic aneurysm with octopus graft, graft balloon component is outside LT renal artery causing type III leakage. 3rd grade arteriogram via LT renal artery Octopus graft in type III intra-graft leakage, stent LT renal artery with the clearance of the thoracic octopus graft component in the LT renal artery. Stenting is performed by ir doctor and vascular surgeon. Vascular surgeon performed cutdown LT axylia artery. Access is made to the axylia lt artery w / direct puncture. Trading in LT artery subclaves, descending thoracic aorta first using Omni Flush catheter inside an RT lateral component of the graft, eventually in LT renal artery tip. ViaBahn stent placement. Stent & LT kidney graft component then lined with a self-expanding stent. The octopus graft component of the lt renal artery is dislocated from the LT renal artery, causing a type III leak. Stenting LT renal artery w/re apposition of LT renal octopus component in LT renal artery. Hi Dr.Z, After an overnight thrombosis in the SFA, the comes for evaluation and was diagnosed for a thrombosis of the fibula artery using thrombectomy & angioplasty for stenosis in the anterior hen artery. I'm not sure we should code the catheterization as 36247-52 for this case. Please specify when to encode catheterizations together with treatments the next day of treatments. Therapies. Prabhavathi, India Left joint iliac was selected and angiography of the left foot from knee to ankle. Ultrasound is used to detect pickled veins in the medial ankle, lateral calf, and medial leg below the knee. Butterfly needles were used in the three areas to perform a venogram before infusion. Doctor encoded 36247 x 2, 36471, 76998, 36005 x 3, 76942, and 75710. Stenosis is placed on the left outer iliac. The left femur bypass graft is accessed and a thrombolysis catheter is placed. Code 37221 includes catheterization and code 37211 does not. Can 36247 be encoded separately with a modifier to place the catheter in the bypass graft for thrombolysis? I have a report that says that the IMA and its peripheral branches have been selected. It then gives findings of the left colic and a branch for catheter placements. I'm confused that he went to the left colic and then to a branch. Would it be 36246 and 36248, .r would it be only 36247? Left heart cath is ordered for a patient with unstable angina. The functional report states that the patient also has a small leg ulcer, a history of arthrectomy in the SFA, reassuring the ABI. Cath is made through right radial access, then catheter is moved down to the right CFA and run-off of the right foot with digital removal in 2 levels performed. CFA is normal and arthrectomy site is patent. This should be reported with codes 93458, 36247, and 75710; I know you can encode for a separate catheter placement when a catheter is inserted through different access or a higher degree of selectivity. For the higher degree exception, the catheter must be in the contralateral leg; For example: If the document performs angioplasty on SFA/POP and then moves the catheter to the anterior knivosis for thrombolysis (ipsilateral), would that be 37224/37211? Could the catheter be considered higher grade (36247) since it went further down then the angioplasty? Vessel catheterization: Section 2 hepatic artery causes a subsectional vessel that is the small supply in large volume spanning sections 2 and 3. Vascular catheterization: Submedic branch of section 2 hepatic artery. The codes are 36247 and 36248? Based on previous responses it has been noted that the right gastric is usually a branch of the left liver, which I can see in the Celiac Arterial Anatomy chart in your publications. My question is about coding when both of these vessels are catheterization in the same case. If the left hepatic is catheterized peripheral to the origin of the right gastric, would you consider it to be a separate placement (36247, 36248); I would have the same question about a scenario that the right hepatic and cystic. Hello, If you can please explain to me what subselective angiography really means. Does it mean subselective medium is higher than the first row? In the following example I have enough documents to support something higher than a first order? Codes 36245 or 36247, 75726 and 75774 Thank you in advance for all your help and feedback.. Here's an example: The was used again to gain access to the IMA and an angiogram revealed the vasoconvulsive had been relieved. The microcathm was reinstalled and a GT 018 cable has now been used. Several other bouts of vasoconvulsive slow progress, however subselective angiography of all left upper quadrant arterioles revealed no active extravasation. Code 36247 Rt & 75716-26, right? What am I missing? REQUIREMENT: Non-metallic wound on the leg. PROCEDURE: 1. Peripheral aortic angiography w/non-selective bilateral iliac angiography. 2. Rt faria angiography w/ runoff (via third grade). 3. Lt farial angiography w/runoff. 4. Successful atherectomy of the middle right SFA using TurboHawk. 5. PTA of femoral popliteal artery. Hello, Dr. Z! We attended your webinar late last year on 2011 Updates on Invasive Radiology, Cardiology, and Endovascular Surgery. When reviewing the brochure, I have a question. On page 8 there is a slide: LE Endovascular Revascular Revascular Case 2. Your 2011 encoding for this is on page 9. We noticed that you have listed 36247-59 which is a catheter code. We are confused because we believed that the catheter codes are now accumulated in the process codes that were 37227, 37231, 37233. Thanks so much for the help! RCF accessed advanced catheter in the abdominal aorta. The catheter was then placed in SMA, celiac disease, left hepatic, medial branch of the left hepatic, left gastric and right aeritis. arteriograms were performed on each artery selected. Embolism of the right gastric artery (volume). I was thinking of reporting codes 36247, 36248 x 3, 75726 x 2, 75774 x 5, and 37242. Can you confirm my passwords? A patient undergoes AAE for fibroids. The left artery of the uterus is selective catheterization, and embolism is performed (36247, 37243). After the procedure, the catheter is repositioned in the ipsial internal iliac artery. Selective angiography confirms the agenesis of the right artery of the uterus, which was observed in the original pelvic angiography at the beginning of the case. The catheter is removed. no embolism is performed on the right side. Is it appropriate to add code 36245 for catheterization of the right internal iliac artery, considering that it was not carried out for embolism? Please do not include any actual medical records of patients with your question. contralateral catheterization of SFA(36247) by infusion of eccular catheter (37201, 75896) carried out on the first day of SFA. returns the patient after the day and follow-up angiogram (75898) finds blocked peronal artery and peronal artery is selectively powdered and AngioJet Thrombectomy performed the peronal artery (37184)--- We encode the catheter selection of the peronal artery (36245) the day or is it still the same catheter placed on the first day and only 37184 and 75898 will be encoded for the next day? Thanks. Dr. Z, I need some advice on coding this case. The doctor dictated two angioplasty to the left renal artery. One was for intimal hyperplasia within a previously mounted a nod to a lesion. The second angioplasty was for the aphthous air of a subsectional branch. I think this should be 75966, 75968, 35471, 35471-59 and 36247. However, as I searched your database, you recommended that 2 angioplasty should only be charged in cases where you could report 2 separate catheter placements. Am I trying to over-code it? Thank you for your help? Chris McCoy Procedures performed: 1) Left groin access under ultrasound guidance. 2) Bilateral lower extremity angiography with peripheral adogram. 3) PTA and atherectomy of cfa right and proximal SFA. 5) Intra-arterial nitroglycerin and Mynx closing device for the left groin. 6) Selective catheter placement in the right CFA and angiography. I mentioned this with codes 76937, 75716-59, 37225, 36247-59, 37202, and 75896. I'm not sure about the peripheral aorta. What code should I use for this? For the following example, is the code 36247 billable for choosing the correct SFA because it was more peripheral than where the intervention took place? Also, is it acceptable to reason for the recall of the catheter in the left CFA with subsequent run-off (36140)? Access via left groin, catheter is placed in aorta for dx aortogram (75625). Advanced right-hand SFA catheter for selective RLE run-off and catheter retracted into the ipsialeral left joint femoral artery for LLE run-off (75716). Access is then justified by the right side for kissing the pottery and stent of the common dizzying (37221-RT & -LT). A patient comes on the first day and has an aortogram and right lower limb angiogram. Doctor starts injecting TPA into SFA, then later in the day makes a follow-up. Second day, do a follow-up and left lower limb angiogram. My codes are 37201, 75896-59, 36247-RT, 75625, 75710-RT and 75898 for the first day. Day two 75898 and 75710-LT. You need to code for two separate lower limb angiographers or combine them using 75716 since it was an ongoing process. Thanks, Cynthia Boyer Diagnostic arteriography was done with vascular catheterization in the right hepatic artery and left hepatic artery. There is a hypertrophic right gastric artery resulting from the left hepatic artery. Then the embolism took place in the right gastric artery. Technical Summary: Successful MAA mapping of section 4A/8 fault (36247, 36248). Successful curl of the right gastric artery with 3 x 15 mm Ruby coils (37242, 36248?). catheter back to select the splenic artery, will 36248 be charged for the splenic artery, even if the doctor has already chosen a third row away from the common hepatic? 36247 will be encoded for correct hepatic, 36248 for GDA and 36248 for splenic artery. Would the following be the correct codes for selective imaging? Right femur access > left inner iliac artery (36248) -> left joint femoral -> left artery profunda -> branch of the left artery profunda (36247-more distant range) Illustration: 75736 for internal iliac artery catheterization, 75774 for profunda branch imaging I'm wanting clarifications catheterization of the liver. In dictation, it sounds like the doctor accessed an artery versus two sections. Here is a sample of its formulation: with the catheter in place within the 5/8 hepatic artery, with the catheter in place within the 6/7 hepatic artery, and the microcathetic was advanced to section 4A/ 4B hepatic artery. I code this 36247 and 36248 x 2. Please inform. Function: Endovascular repair of the thoracic aneurysm with fenestratid stent graft (4 branches) of the visceral arteries and peripheral difurized aortoiliac stent graft. Repair of the right joint iliac artery aneurysm with iliac branch device. Percutaneous coil embolism of the right inner anterior branch. Left duct of the axylia artery for the delivery of stent graft components. Can I report selective catheterization of the patient's maternal right internal iliac anterior division (36247) and posterior division (36248)? Is this enough documentation to support encoding 37243, 36247, 75726-26-XU, 75774-26-XU, and 96420 (installation only)? Through the left joint access of the femoral artery, an selective arterial coeliac in the portal venous phase showed the hepatic artery of origin from the celiac axis and the absence of a replaced right hepatic artery and patent portal vein. Selective right hepatic arteriogram shows tumor reddening in the lower right hepatic lobe and liver dome, both coming from branches of the right hepatic artery. Chemoemoxation using mitomycin, pva, ediodol, saline, and contrast was administered through the catheter to the right hepatic artery. I would appreciate your help on a topic we have with the right codes to use in the following case: Access was from the right common femur. The catheter was placed in left internal iliac, upper gluteus, and two separate branches of the upper gluteus (36247, 36248). The left outer iliac was then catheterization. I believe that the left outer iliac will be referenced by code 36248, since these vessels are in the same vascular family (contralateral common iliac family per boat order table from the SIR manual). The other view is that the left outer iliac will be referenced by code 36246 based on your pelvic arterial anatomy diagram. Can you clear this up for us? If an angiography is done during an intervention that is not a diagnostic study, you would encode and charge the placement of the For example, embolism of a liver tumor. The doctor selectively catheterizes the cystic artery, right hepatic artery, and branch of the right hepatic artery. Findings: The location of the cystic artery confirmed, both the main right hepatic artery and the branch of the right hepatic artery were confirmed confirmed provides the volume. Intervention: The catheter was advanced in the correct hepatic branch and became an embolism. The codes I use are 37243 and 36247. Will you also mention the code 36248 for the placement of the cystic artery? The left hepatic artery was catheterized and diagnostic angiography was performed. One third of the 5 mCi 99m-Tc-MAA dose was administered to the left hepatic artery. The SMA was then selected, and, using the progressive microcathm, the replaced correct hepatic artery was selected and the diagnostic angiography performed. The other two thirds of the dose of 5 mCi 99m-Tc-MAA is then injection. I mentioned codes 36247, 36248, and 36245-59, but the reviewer insists that code 37242 should also be reported. What do you think? I have a difficult Y90 mapping that takes 100% extra time, and the doctor asks for modifier -22. This is a patient who is not Medicare. I found that for codes 36247, 36248, and 75774 the -22 modifier is allowed on the professional side. Per Medicare guidelines (modifier -22 can only be reported with process codes that have a global period of 0, 10, or 90 days. Other procedures are not eligible for modifier -22. Codes 36248 and 75774 have a worldwide XXX period. Can we still charge them with the -22 modifier since this patient is not Medicare? I have a question about modifiers -RT and -LT for lower edge processes (37220-37235 and 36245-36248). When the intervention takes place only on the unilateral part, should we attach the modifier -RT or -LT? How about diagnostic angiography? For example, when the stent was done on the right femoral artery, should we attach the modifier -RT to 37226? In the other case, the patient had right lower limb angiography (access point: left joint femoral artery, catheter location: right joint femoral artery). Do we attach a modifier -RT or -LT modifier to code 36247 next to 75710-RT? We are having a discussion between us and we would like your opinion on this case. The patient comes with hemochromatosis and hepatocellular carcinoma. MRI shows persistent nodose strengthening with the right medially lobe. Correct CFA approach. Kannuri tosses coeliac disease, pic. Advances in two correct liver branches, pic. They're both vaccinated. Moves to the left hep, pic. Moves to the right lower femoral artery from celiac disease, pic. The inglon inhales the peneral artery. The doctor may tend the right hepatic accessory from SMA, pic. We have codes 36246, 36248 x 3, 75726 x 2, 75774 x 5 and 37204/75894. The conversation is... Are we missing a 36247? And we can't charge code 75898 for embolism monitoring? Can you please help clarify when to encode diagnostic angiography? As we know the patient has cancer, and arteriography and embolism were planned, would these codes be correct: 37242, 36245, 36247, 36248 x4, 72726 x2 (59), 75774 x3 (59)?? CLINICAL HISTORY: Woman with hepatocellular carcinoma and hyperspelism presents today for Planned Arteriography embolism in preparation for planned radioembolisation. PROCEDURE EXECUTED: 1) Selective upper mesenteric artery angiogram. 2) Selective celiac angiogram artery. 3) Selective correct hepatic, right hepatic, left hepatic, and middle hepatic artery angiography. 4) Injection of Technicium-MAA into the correct hepatic artery. 5) Selective splenic angiography of an artery with embolism. Angiogram (DSA) of the entire left lower extremity and iliac arteries using a 4 french x 45 cm long Rim catheter proceed from the right joint femoral artery up and up and down to the left SFA. Selective angiogram of the left posterior tibia, peronal and anterior tibia using a Navycross catheter 4 x 150 cm long advanced from the right joint femoral artery above and above the left lower extremity. Confirm the use of the correct codes: 36247, 36248, 76937-26, 75710-26; Patient supine at the table puncture right joint femoral artery proceed to the abdominal aorta and then catheterization of celiac disease w / arteriogram then cath splen artery with arteriogram. then select 2 branches of the upper division of the splenic artery w/arteriogram, with mild embolism in posture followed by a subselection of 2 branches of the lower splenic artery w/arteriogram and mild embolism. we would use for cath codes 36247 a branch of the upper division, 36248x3 for 2nd branch upper division and for 2 lower branches division 75726 and 75774 x4 and 37242 for the embolization code. The interventional radiologist orginally punctured the right common femur and then catheterly and illustrated the left hypogastrical. Then selectively catheterization and image of the left upper gluteus, left lower gluteus, and the left iliofemoral arteries. I have the following codes so far: 36247, 36248 x 2, 75736, and 75774 x 3. He then catheterized the left circumflex iliac artery and the left lower epigastrical artery and did diagnostic imaging on both. I'm not sure how to encode these two except for the above codes. All imaging was done to control the bleeding. The patient is after the wound with internal bleeding. I hope you can help with this case: Female patient with excessive postpartum bleeding presents in IR for possible embolism of bleeding vascular source. No previous diagnostic study was performed. Bilateral selective (internal iliac arteries) pelvic diagnostic angiographies, complete (75736 x 2) and bilateral hyperselections (uterine arteries: 36247 x 2) diagnostic angiographies, complete (75774 x 2) from the left groin were performed. Diagnostic angiographs discredited sources of bleeding led to a decision on embolism. The embolism took place, bilaterally, with subsequent after embolism (37244). Can we encode and charge diagnostic angiography along with the embolism in this encoding scenario? Please do not include any actual medical records of patients with your question. You could review these codes and let me know if the case was encoded encoded Function : Aortagam with pelvic run-off, obstruction of the right inner iliac artery with Amplatzer plug, suction of left lagonal aneurysm with branched iliac device, repair of infrared aorta with dichotomy of stent graft (zenith cooking) angioplasty and stent of the left outer iliac artery. Dx are aneurysms of infrared aorta and bilateral common iliaa arteries. The selected CPT codes are: 34803,34900,34825,34808,37221,36247-59,75952-26,3 75952-26/59,75953-26,76937-26,75937-26/59 In case you need a copy of the case pt. please let us know. Thanks, Renata Question on appending laterality modifier to new regional intervention codes: Since the application of CPT 2011 codes, the option to select the laterality of the side being treated (especially -LT or -RT for the lower end vessel) - is not available in 3M in the category OPPS modifier. You MUST select all modifiers from the modifier category. After you select and append the modifier for laterality and calculate, you receive a 3M message according to the following: The modifier -LT (left side) or -RT (right side) may not be appropriate as assigned. However, for cpt that is not new / did not change from last year; e.g., 36247, you can still select -LT or -RT from the OPPS modifier category. Should we limit the request for amendment to the intervention of regional vessels to -59 for the state of intervention in both arms? Thanks. The patient was transferred to the IR suite with an ir leg. A pelvic angiogram was performed and the catheter was forwarded to the right in the outer iliac and a lower limb angiography was performed. The catheter was advanced in the fem-pop graft that carried out an angiography showing thrombosis. Probe advanced in the above knee jump graft below the knee showed 90% stenosis. Angioplasty took place in the graft anastomosis jump. An infusion catheter was then inserted into the fem-pop graft and then an infusion cable was forwarded through the infusion catheter into the peronal artery. Overnight thrombolysis took place. I know catheter placements are stacked in pottery codes. Can we code 36247 for the placement of the infusion wire in the peronal artery, since it has passed through the position of angioplasty? I need your guidance, please. The patient has a type 2 endoleak and comes in for angiography and possible glue embolism. This is the condensed part of the report: The correct CFA was accessed with a micro-trap system. This was exchanged with a hard Glidewire, short 5 French casing, and pigtail catheter. The aogram with mesenteric runoff was done. The IMA entering the bag has been identified. A 0.18 Glidewire and Renegade catheter were used to riolan's thorny bow and have access to the IMA and the bag. Glue was diluted 1:3 with oil, and 3 cc of it was used to embolism of the sac and peripheral IMA. I mention the code 37242 for the embolism, but I'm not sure about the placement of the catheter. The doctor mentioned that this was a third order. Since SMA and IMA are two separate families, families, Will I mention codes 36247 and 36245-59? Since the lower epigastrical artery exits the outer iliac, will codes 75716 and 36247 along with 75898, 37204, 75894, and 75774 be appropriate? 5 French catheter is advanced in the abdominal aorta through the left femur, followed by abdominal-pelvic arteriography. Then, the catheter is advanced throughout the aortic branching, followed by more focused angio of the right iliac vessels. Extravasation resulting from a muscle branch of the medial lower epigastrical artery. 3 French microcather selectively propelled to the right lower epigastrical artery. Repeat angio confirms acute bleeding. Gelfoam is injected until there is no proven flow within the peripheral lower epigastral vessel. Finally, the 3 mm microcol is placed immediately close to the vessels that previously fed the bleeding area. The specific angiography of the contralateral lagonium system is not remarkable. I've read previous topics and I have a question about the surgical field. Encoded by a hospital, the procedure was an embolism of the right hepatic artery with Y90 microbeads. (37243) dx is metastatic liver cancer. During the procedure and prior to embolism of the right hepatic artery it was found that the proximal GDA had to be vaccinated. Therefore, the GDA was inoculated with an MVP plug and coils. Once this became the correct hepatic artery was vaccinated, normal anatomy, with Y90 microbeads. The right gastric artery was previously inoculated. Vaccinations of GDA & right hepatic artery were performed at the same and the same surgical session. It is considered the same surgical field and only 37243 is encoded according to ncci treatments or we can code 37243 & 37242-59 (XE) because the GDA embolism was not done to treat the cancerous area. We also encoded selective catheter settings 36247 & 36248. I have a case, and I don't know if there are too many codes for it. Please let me know if I have the correct codes: 37242 x 2, 75736 x 2, and 36247 x 2. Cervical ectopic pregnancy; selective catheterization of the left iliac artery is performed. DSA imaging is performed followed by hyperselective catheterization of the left artery of the uterus. There is hypervascular of the uterus, according to the condition of the patient gravid. Increased flow is observed in the area of the cervix. Embolism is performed with PVA particles and embolism coils until it almost stops. Then, catheter is advanced to the right internal iliac artery, and DSA imaging is performed. Similarly, hyperselective catheterization of the right artery of the uterus is performed followed by a similar embolism. The patient tolerated procedure well. There are no immediate complications associated with Hypervascular matrix. Successful bilateral uterine artery embolism. Patient the next day EKOS lower extremity. Re-illustrated still heavy clot load seen. Doctor balloon anterior tibia, posterior tib, and peroneal artery plus suction catheter each balloon after the vessel due due to clot observed in the same container. There is no documentation of stenosis in these vessels. Restarted EKOS patient brought back the next day for angiojet at PTA and peronal and thrombolytic spray via AngioJet for 20 minutes to post tib plus stent placement to post tib due to dissection. The second day was coded by staff as 37213, 37228, 37232. Based on my understanding of what I read in your book should be encoded as 37213, 37184 (after tib), 37185 (anterior tib), 37185 (peron), 36247. The third day must be 37214, 37184, 37185, 37230. Is that right? There is disagreement and confusion about what an angioplasty is and what is thrombectomy in cases like these. Hi, We have a question about a thrombin injection of a right SFA pseudoanyurysm using a ballon to blcok the boat. We understand that code 36002 and 76942 has been assigned for injection. However, should we also add 36247, 75710, and ?37799 for the balloon blocking section? Thanks! We felt lower limb angiography with balloon locking of the neck would help with the process and prevent thrombin from migration to the native vessel. Access was gained through the left femoral artery. We passed over using a lip catheter with a Glidewire angle. Then we were able to exchange with an Amplatz cable. Then we placed a destination casing. We used a 5 x 40 balloon to block the neck of pseudoanyrism, which was depicted under digitally removed images. Using ultrasound guidance, we insued the pseudo-aneurysm. Doppler's color ultrasound showed no flow later. All equipment was removed, a run-off of the right lower limb was taken. An eclectic hagiography shot of left faria access was taken and a 6-French Angio-Seal was developed to obtain hemostasis. Please explain when to code for catheter placement when diagnostic angiography is done followed by intervention, such as angioplasty/stent in the lower extremities. The procedure today contained the following: Catheter is inserted into the left common femur (contrast injected here), then placed in the

peripheral aorta by angiography and repositioned into a right superficial femoral artery with angiography, and then repositioned in the right poplitic artery by angiography. Then, a catheter was inserted into the left joint femoral artery with angioplasty of the left posterior tibia artery (same leg). Should code 36247 be reported? Also applicable is the following for 2014 (Assistant CPT July 2011): Catheter placement codes when diagnostic angiography is performed at the same time as intervention(s) requires a higher degree of selectivity than intervention. If so, can you give an example? What should I look for about placement of the encoding catheter with angiography/lower extremity intervention (for example, code when diagnostic angiography is done through separate access); Access via the correct common femoral artery, descending aortograms (75630-59) and then selective angiogram of the contralateral popliteal artery. Intervention decision on intervention intervention in-stent retenosis & to open pt damage. He tried to cross the PT fault with a cable supported by a .018 Quick Cross catheter and then a TruePath device, but was unable. Case pulled back into the CFA LT, then 6.0x150mm Savvy balloon inflated to 10 ATM at SFA for 1 minute in stent w/excellent results. 37224-LT assigned. CPT Assistant, Oct 2011 p9, 11 LRevascularization of the lower extremities & related catheterization, advises a higher level of cath can be reported additionally w/-59. Although both are 3rd level selectivity, tibia/peronal soil is further progress by SFA in faria/popliteal soil. Can we mention 36247-59 for putting cath in PT? I'm quite new to encoding regional foot angiography and would like some clarification on whether this coding seems accurate for an OBL setting in Texas. The first patient is the first angiography. Procedures performed: 1) Abdominal angiography with peripheral run-off. 2) Right lower extremity angiogram. 3) Selective injections below the knee in the third row. 4) PTA and atherectomy of the right peronal artery. 5) PTA of the right anterior tibia artery. 6) PTA of the right posterior tibia artery. 7) 70 of the contrast was used zero waste. 8) Moderate suppression monitoring 0715 - 0835. 9) Medication: Benadryl 50 mg, IV Vered 2 mg, IV Fentanyl 50 mcg, intra-arterial nitroglycerin 700 mcg, Plavix 600 mg. I would encode as followsL 75630-XU, 75710-XU, 36247-XU, 37229, 37232, 37232, Q9967, 99152, and 99153 x 4; Can the monitoring of repression continue outside the courtroom? Can I charge for any of the drugs listed? The patient has left the thigh pain with fatty penetration of the muscle vastus lateris, here for immediate hardening by puncture, treatment like vascular dysplasia. Successively access to different points w/ in dysplasia w/ 21 needle counter injection contrast to determine the anatomy of the lesion. Sotradecol foam is injected to spread w/in damage. Skin cleaned and dressed. Then RT CFA access, wire passed centrally, 5 F4 C2 cath passed over wire to select LT ICA anterior division (36247) w/imaging (75736-LT), Cath then pulled back && selected LT CFA (36248) w/imaging (75710-LT) that showed no abnormal vascularity. Final was LT vastus lateralis focal fatty filtration treated as vascular malforamtion. There is no evidence of AV dysplasia. This sounds like an immediate puncture of the pickled vein hardening, but there were no vascular findings or location treated. How will this process be codified? Right common farialy access and thread to AA. The aortogram was performed with documented findings. Wire passed to the left outer iliac, and lower limb arteriogram was made with findings Stenosis. Rubicon cath passed over wire on superficial femur on the left side. Repeat arteriogram was done for intervention. I had a thromboectomy on the left part of the fem pop. After that, the atherectomy of the fem pop section was done on the left. A drug-eluting balloon passed over wire, and angioplasty took place in the fem pop section. Artiogram confirmed confirmed Results. Balloon was removed and case pulled back to the right iliac. After that, a balloon was raised on the right side to the near right common iliac, and a balloon mounted stent was raised on the left side. Stent developed into proximal left joint iliac. This is done as the right side balloon brought up for support. The provider wants to account 37221, 37225, 37220, 37184, 75710, 75625. I'm not sure when I'll charge 75710 & 75725 with the procedures. Am I going to charge 36247? Is it advisable to add an additional code cpt 36248 for proper hepatic when a diagnostic arteriogram, if performed? Coeliac disease was selected, type 1 coeliac anatomy, selected common hepatics, G.D. was selected. To prevent regression and non-target embolism in GDA. The seat was placed in the appropriate hepatic artery, an arteriogram was performed. The r. gastric artery was detected resulting from the r. hepatic artery. This was chosen microcath, arteriogram done. To avoid regression and non-targeted embolism in the RGA, the RGA was blocked with coils. The defendant was directed deeper into the R. hepatic artery, arteriogram carried out. 1.5 mCi of 99 MAA technology was injected into the r. pod. The defendant then headed to the hepatic artery of L. 2.5 mCi of the technology 99 MAA was injected into the lobe l. Codes used: 37242,36247(G.D.),36248X4 (correct hepatic, r. gastric, r. hepatic, l. hepatic) & 79445. My understanding is that we can add a 36248 for proper liver because it stopped at this level to do a diagnostic arteriogram. If the defendant went from the appropriate to the hepatic, did not stop doing an arteriogram of the appropriate hepatic, then we will choose the highest placement of the sitting; Please help this code. Indications/NOTES: HCC/ U.S. CHEMOEMBOLIZATION RESULT: COMPARISON: 5/28/2012 HISTORY: 68-year-old male history and hepatocellular carcinoma. PROCEDURE: Chemoembolization. After obtaining informed patient consent is placed in a supine position in the angiographic table. The right groin was ready and dressed in the usual sterile patterned. Ultrasound imaging of the common femoral artery was performed and access to the common femoral artery was received. A 19-gauge needle was inserted into the artery and ultrasound observation a 035 cable was forwarded to the abdominal aorta. 5 French vascular sheath was placed in the area of arteriotomy. After that, Cobra 2 catheter was advanced in the abdominal aorta and used to select the origin of the celiac artery. The contrast was injected and the images taken. Due to the lower course of the celiac artery, the Cobra catheter was exchanged with a Simmons 2 catheter. This catheter was placed at the origin of the celiac artery and promoted to the hepatic artery. The contrast and the images taken. After that, the microcathetic was pushed coaxially through the catheter. The high-flow renegade catheter and microsyrino were used to select the origin of the left hepatic artery. Chemoembolization was injected approximately 20 mg mg Doxoroubicin in liver spheres. The antegrade flow was monitored throughout. The microcatheter was then pulled back into the main hepatic artery and proceeded to the right hepatic artery. Only a small amount of Doxoroubicin was injected as the patient has a known blockage of the portal vein. The antegrade flow was continuously monitored to ensure or the hepatic artery would not be compromised. Random note is made by vascular staining in the dome of the liver and in the posterior right lobe of the liver consistent with known tumors in the CT scan. CONCLUSION: Limited chemoembolization of the left and right hepatic arteries as described above. A total of 60 mg of doxoroubicin in hepatis spheres was injected. Antegrade flow remained present throughout the procedure in both liver lobes. The narrow star device was used to achieve hemostasis in the correct common femoral artery.. I have 75726, 75774, 36247, 36248, 37204, 75894, G0269, 75898. He's a patient at the hospital. Thanks... will be able to help. I use your book when I encode these, but I would like some validation that I'm using the right codes. PROCEDURE: 1. Superior angiography of the mesenteric artery. 2. Accessory right hepatic artery angiogram resulting from the upper mesenteric artery. 3. Angiogram coeliac disease. 4. Selective left gastric artery angiogram. 5. Selective gastropancretic joint trunk angiogram. 6. Coil embolism of this common pancreatic gastric trunk. 7. Selective left hepatic artery angiogram of two partial left hepatic arteries. 8. Selective right hepatic artery angiogram. 9. Gastrododan artery angiography. 10. Pulmonary artery coil embolism. 11. Infusion of MAA approximately 2.5 mCi Tc 99m MAA into the auxiliary right hepatic artery resulting from the upper mesenteric artery. 12. Infusion of MAA approximately 2.5 mCi Tc 99m MAA into the right hepatic artery resulting from the celiac artery. DESCRIPTION OF THE PROCEDURE: The patient was placed supine. The right groin was ready and draped in the usual sterile way. The skin and deep subcutaneous soft tissues were stunned with 1% lidocaine. A small skin alias was made with a #11 blade, and then using micro-acquiring technique, the correct common femoral artery was accessed and a microwire advanced. Over the microwire a #5-French microseth was placed. Through the microsheath a 0.035 3-J cable was launched into the abdominal aorta, and over the cable a #5-French working sheath was placed. Above the wire and through the casing, a #5-French Sos Selective catheter was placed over the wire and formed in the abdominal aorta. It was then used to select the upper mesenteric artery and a digital removal of upper mesenteric artery angiography was performed, and a microwire Progress and microcatheter, the microwire and microcatheter were used to select the auxiliary right hepatic artery resulting from the upper mesenteric artery proximally. A digital removal of right auxiliary hepatic artery angiography was carried out, which dominant supply to a hypervascular complex of right-lobe liver mass along with several satellite lesions. The right hepatic artery component provides a moderate amount of the right lobe of the liver, possibly more than half of it. The microcathetic catheter was then removed and the selective Sos catheter was used to select the celiac artery. Digital removal of celiac artery angiography was then carried out. This reveals a complex configuration of the celiac artery with two left gastric arteries resulting from the branching of the common liver and splenic, as well as a very large pancreatic gastric trunk. Using Progress microwire and microcatheter, the cable was used to select the left gastric artery, and a digital removal of left gastric artery angiography took place. Then, using Progress microwire and microcatheater, the gastric pancreatic trunk was selected. This comes out in a trifurcation fashion with gastrodedecadyntic right and left hepatic branches. This pancreatic gastric trunk was selected and then back-curled with 0.018 vortex microcoasts to complete the stand. The handmade arteriogram was carried out documenting the adequacy of the embolism. The left hepatic artery was then selected. There are two left hepatic arteries, section two branch first selected and digital angiography removal performed. The three-branch section was then selected and the digital abstraction angiography was done. The next right hepatic artery was selected and the right hepatic artery angiography was performed, which showed a supply of branch vessels to part of the hypervascular dominant right lobe-of-liver hepatocellular carcinoma. The gastrodedecadactynal artery was then selected and an angiography of digital removal of the gastrododecadacty artery was performed. This was then coiled to complete stop using Nestor microcoil as well as Azure detachable coil. The gastrodededactynal artery was curled to complete the stop and a meta-coil angiogram was performed documenting the adequacy of the embolism. Then, the catheter was inserted into the appropriate hepatic artery upstream into the cloverosis of the vessels. 2.5 mCi Tc 99m MAA was then injected into this site. The delivery materials were then safely made available by the nuclear medicine technologist. A new Progress microwire and microcatheater were placed after the Sos Selective catheter was used to select the upper mesenteric artery. A microcatheter was then used to select the auxiliary right hepatic artery and the remaining dose of maa was administered. 2.5 mCi Tc 99m MAA were injected into the correct auxiliary hepatic artery. Infusion materials were then safely removed and made available by the nuclear medicine technologist. The right housing in the country was then removed and excellent hemostasis is achieved by using manual compression for about 15 minutes. My codes are 37204 and 37204-59, 75894, 75894-59, 36245, 36246, 36247-59x3, 36248 x's3. Thanks for your help in advance... of the right extremity with selective catheter entanglement in the right superficial femoral artery. 2. PTA of the right damage. 3. Placing an infusion catheter in the right anterior tibia artery due to a clot at the end of the procedure. INDICATIONS: 1. Zero ulcer on the right lower extremity on the right above the ankle. 2. Severe symptoms of lameness in the right lower extremity. 3. Severe peripheral vascular disease from ct angio of the lower extremities arteries. PROCESS DETAILS: A-5 French sheathe was inserted into the left joint femoral artery under local anesthesia using the Seldinger technique. After inserting a 5-French case I got a J-wire with a 5-French catheter. Then I brought in the catheter and wire over the iliac branching in a retrograde way to the superficial femoral artery and placed the catheter there and took photos of the right lower extremity. Angiographic results revealed that the right peripheral superficial femoral artery indicates disease. The right popliteal artery shows about 60% to 70% damage. The right anterior hen artery shows total obstruction in the middle section with reconstitution above the right ankle. The right tbioperonal trunk has mild disease. The right posterior tibia artery indicates mild disease. The right peronal artery presents mild disease in the proximal middle part with a peripheral portion that looks completely blocked and regroups just above the foot. I used a 6 French 45 cm long destination sheath brought over the iliac branch placed in the correct common femoral artery. Then I used a 20 cm J wire length exchange and placed it in the SFA. I brought the slip catheter and pulled out the J cable. Then I used an Angiomax bolus drip according to weight-based protocol and creatinine clearance protocol. This is a Rapid Crossing probe. I removed the guide catheter and replaced the Quick-Cross catheter. Then I used a .014 wire guide, which is a prowater length cable. Then I used the cable and crossed the anterior hen artery and put it all the way to the end. Then I used a balloon to inflate all the damage. The balloon is a 3.0x150 elegant balloon and inflated anterior tibia artery in about 10 atmospheres of pressure. Then I used a 5-French echo sheath tempo catheter, took the wire out and took good photos. It showed there a good flow to the anterior tibia artery with focal stenosis of 95% in the middle section. Then I went back with the wire Asahi Prowater used a 4.0x150 mm balloon and tried to dilate the entire tibia artery, especially throughout the damage to about 6 to 7 atmospheres of pressure. Then I got good flow with good flow all the way to the foot, but considering the severe calcification across the artery, to get better result, I went with a 3.0mm balloon again and dilation. After the last flow to the anterior hen artery. Also, I see the flow the posterior tibial artery and the peronal artery got slow and eventually the flow became very faint in the peripheral parts of the posterior tibia artery, as well as the peroneal artey, which did not interfere at all, and never had a script placed in Artery. That's when I realized there was some thrombotic state, possibly from the Angiomax problems. Either not given enough or the Angiomax given was not enough anticoagulant. He re-t-shirted the Angiomax at that point. Then I tried to reverse the leak over the wire balloon and tried to dilate several times, giving intra-arterial nitroglycerin and verapamil. Still the flow was less with a clot. The flow is minimal. Then I used Activase intra â€ arterial with catheter placed in the anterior region of the tibia artery. Then I used a 10 mg IV bolus given initially and then I started infusion. I then inserted an ev3 infusion catheter. The catheter is placed in the anterior hen artery that extends to the popliteal artery. At that moment I left the catheter in the popliteal artery and left the catheter in place and gave another 2 mg IV boost of activity and began a drip. This lasted for 6 hours with the plan to bring him back for re-angiography and possible PTA. The patient tolerated the procedure, hemodynamically, stable without any problems from a respiratory or cardiac point of view. Also another procedure was performed, which was PTA of the popliteal artery. There is a 70% damage to the popliteal artery. I used a 4.0 balloon to do the PTA of popliteal damage to about 8 atmospheres of pressure. The balloon was extended from the proximal AH to the popliteal artery. CONCLUSIONS: 1.70% damage to the right popliteal artery 2. Total blockage of the anterior tibia artery in the middle part. 3. Thromboembolism of the infrared arteries during the operation leading to poor flow to the leg, requiring bolus and Infusion Activase using the infusion catheter. The infusion catheter is an ev3 infusion catheter. 4. At the end of the procedure, the patient must have posterior tibia Dopplerable and anterior tibia Dopplerable pulses. Recommendations: 1. Continue infusion with Activase for 6 hours. 2. Repeat the angiography after 6 hours of infusion of Activase. My encoding is 37228, 37224, 75710-26, 59 & 36247 (Placement of infusion catheter not for angiogram). Repeated procedure on the same day: Indications: 1. Thromboembolic phenomenon in the infrared arteries in the PTA of the right popliteal lesion, as well as the completely obstructive anterior tibia artery. 2. Status after infusion Activase over 6 hours to see how the clot load in the infrared arteries and the right lower extremity, and possible intervention. HISTORY: This is a 73-year-old white male with a history of significant peripheral arterial disease, with a non-debilitating ulcer on the right lower extremity above the ankle. He was found to have a significant disease infrapoplelital. The patient had pta of the damage of the popliteal artery, as well as the intervention of the anterior cemoral artery of the right lower extremity during which the patient developed phenomenon leading to a good flow in the infrared arteries with poor circulation to the foot. An infusion catheter and an infusion of the It took over six hours. The patient was transferred for a repeated angiogram a possible PTA. Again, a French destination 6, located on the right superficial femoral artery starting the proximal portion on the right side. The infusion catheter was already in place, which was at the tip of the popliteal artery, anterior hen artery. Then we cleaned this in a sterile way and changed the gloves, got an angiogram of the right lower limb. RESULTS: 1. Angiography of the right lower extremity showed the polytic artery damage was less than 30% 2. Anterior itching artery flow was again not well observed. 3. The peronal artery also showed good flow with peripheral reconstitution after obstruction in the peripheral portion. The peripheral part of the reconstitution was just above the foot. Then I gave him 4000 units of endoparin. Then we used the same catheter. Through the same infusion catheter I inserted a Benston cable and placed it in the anterior hen artery all the way to the foot. Then I used a pottery with a balloon that is 4.0x100 balloons. After PTCA the flow is slightly improved, but not to a large extent. Taking into account the recent complication of thromboembolic problem in the lower extremities, we reconciled with the results and had partially successful results on the opening of the anterior tibia artery. The posterior hen artery and peronal artery stayed as they were at first. No complications. My coding is: 37228-76 & 75710-26.76 I appreciate your help. Thanks & Regards Ronald Search Again Again